

# CALIFORNIA AND WESTERN MEDICINE

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Official Journal of the California Medical Association  
FOUR FIFTY SUTTER, ROOM 2004, SAN FRANCISCO

VOLUME 62  
NUMBER 1

JANUARY - 1945

50 CENTS A COPY  
\$5.00 A YEAR

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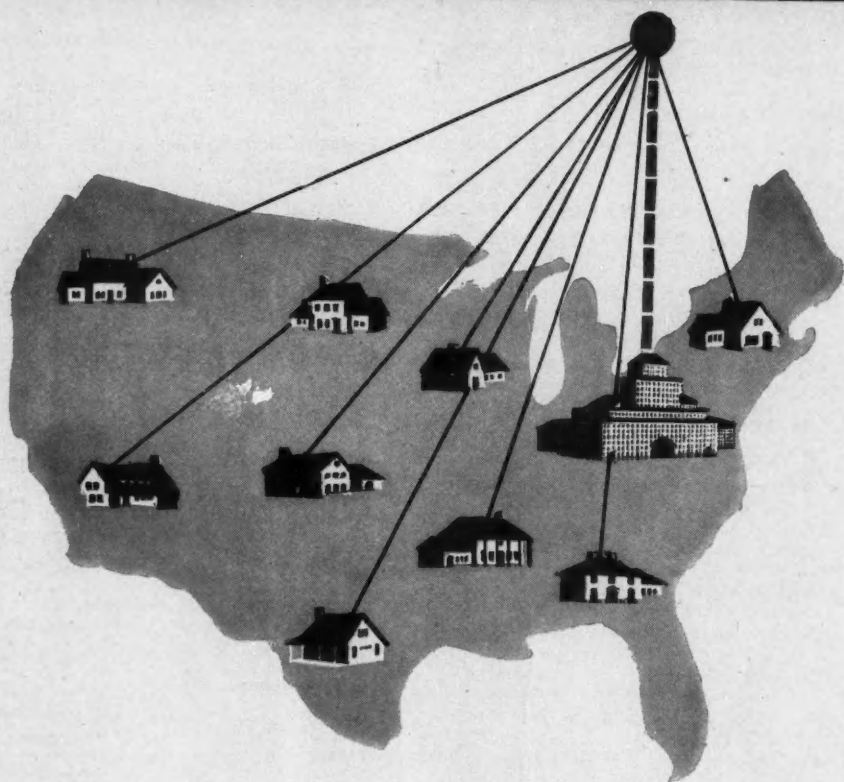
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are treated in the home

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# CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 62

JANUARY, 1945

NO. 1

## California and Western Medicine

Owned and Published by the  
CALIFORNIA MEDICAL ASSOCIATION  
Four Fifty Sutter, Room 2004, San Francisco  
Phone DOuglas 0062

Address editorial communications to Dr. George H. Kress as per address above. Address business and advertising communications to John Hunton.

EDITOR . . . . . GEORGE H. KRESS

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*Advertisements.*—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

BUSINESS MANAGER . . . . . JOHN HUNTON  
Advertising Representative for Northern California  
L. J. FLYNN, 644 Market Street, San Francisco (DOuglas 0577)

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Subscription prices, \$5 (\$6 for foreign countries); single copies, 50 cents.

Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

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*Contributions—Length of Articles: Extra Costs.*—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

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## EDITORIALS

### A COMPULSORY HEALTH INSURANCE LAW PROPOSED FOR CALIFORNIA!

**Background of the Call for the Special Session of C.M.A. House of Delegates.**—On December 2, 1944, Governor Earl Warren and State Director of Public Health Wilton L. Halverson visited C.M.A. Council Chairman Philip K. Gilman in Oak Knoll Naval Hospital, and at that conference Governor Warren told Captain Gilman he felt the time had come for the State of California to provide, through appropriate legislation, broader medical care, and also other protection against the catastrophes associated with illness, for all citizens of California who belong to the lower income groups.

Governor Warren told President-Elect Gilman he was presenting the subject to him that the matter, in turn, might be placed before the constituted authorities of the California Medical Association prior to the session of the Legislature which would convene on January 8. He also expressed his hope that the medical profession of the State would take an active interest in any medical care legislation that would be presented to the 56th California Legislature.

In reply, Council Chairman Gilman said he would promptly arrange for an informal conference at which Governor Warren could indicate to representatives of the California Medical Association his personal views on the subject of medical care for low income groups.

Accordingly, members of the C.M.A. Executive Committee held a meeting on the evening of December 12th at which time the nature of impending medical care legislation, insofar as information was available, received comment.

On the next day, Wednesday, December 13th, in San Francisco, Governor Warren spoke to officers and invited guests, and outlined further his own thoughts on the subject of adequate medical care. In this issue of CALIFORNIA AND WESTERN MEDICINE, on pages 25-40, appear minutes and memoranda bearing on the above and subsequent happenings. A perusal of the digest of Governor Warren's remarks, on page 27, will give C.M.A. members an insight concerning the problem that confronted the Association's Council, and the reasons that led the Councilors to unanimously vote to issue a call for the special

session of the House of Delegates of the California Medical Association, held subsequently in Los Angeles on January 4, 5, and 6. A letter from President Lowell S. Goin on December 20th was sent to every member of the Association. (See CALIFORNIA AND WESTERN MEDICINE, for December, on page 313.)

Since the subject of compulsory sickness insurance has many controversial phases, it is important that C.M.A. members take the time to read the minutes and other information above referred to, so that, in later exchanges of views and discussions, actual facts on what took place may be kept in mind. Through such perusal, useless argumentation, based on personal impressions or opinions, may be avoided.

\* \* \*

**Attitude of California's Governor.**—It is important that all physicians keep in mind that the executive head of the California Commonwealth, Governor Earl Warren, expressed himself somewhat as follows:

The lower income groups of California citizens are entitled to adequate medical care; the State of California has an obligation to devise ways and means through which much medical care will be made available to these citizens; the trend of public opinion and effort is in favor of procedures to provide such medical care.

Governor Warren believes this obligation to provide adequate medical care should be promptly met; and from information he had received, he inferred that legislation designed to meet these objectives would be presented to the 1945 Legislature by Labor or other groups; also, he hoped the medical profession, as an interested party having major interests, would indicate the nature of its wishes and coöperation.

Further, in case the Legislature failed to enact proposed legislation, the Governor believed it was quite possible that interested groups other than the medical profession, through referendum-initiative would pass on to the electorate of California, the responsibility of decision on adoption of one or other medical care plans to be placed on the ballot of the next general election.

Governor Warren remained with the physicians who were present at the December 13th conference, listened to their criticisms concerning phases of some compulsory health insurance systems, and answered questions put to him.

After his departure, members of the Council continued their meeting, and the call for a special session of the C.M.A. House of Delegates, to be held in Los Angeles on Thursday, Friday, and Saturday, January 4-6, 1945, was one of the actions taken. The Official Call, outlining the purposes of the Special Session of the House of Delegates, printed in red ink on a stiff paper insert, appeared in the December issue of the Official Journal, opposite page 281, and is again given place in the current number on page 28.

**Los Angeles Meeting of the C.M.A. House of Delegates.**—Concerning the three-day session of the House of Delegates of the California Medical Association in Los Angeles, on January 4-6, the following may be stated:

Almost every component county society was represented by a full delegation, the absentees being largely from a few of the smaller county units;

The proceedings were marked by intense interest; and resolutions submitted, some thirty in number, as well as the many speeches and comments thereon, and the presentations by representatives of A. F. of L., C. I. O. and the Farm Bureau, all were given careful attention;

The open and executive meetings of the House and of the Resolutions Committee (both open to C.M.A. delegates and members), were carried on through the three days and nights, the Speaker endeavoring to give all delegates who desired to make comment, either for or against proposals submitted, full opportunity to do so;

The progress report of the Resolutions Committee, (consisting of H. W. Bosworth, Los Angeles, Chairman; Dwight H. Murray, Napa; J. J. Crane, Los Angeles; G. D. Delprat, San Francisco; and Walter Beckh, San Francisco), was submitted on Friday, and the revised report presented on Saturday received earnest discussion;

The final report of the Resolutions Committee, as amended, was adopted on Saturday afternoon, January 6th, and was immediately given to the press. This report appears in this issue on page 32.

\* \* \*

**Full Report of Proceedings Will Appear As a Separate Monograph.**—Concerning the full proceedings of the House, these are now being transcribed by the stenotypist and secretaries. The C.M.A. Council has voted that the record of the proceedings be printed as a separate monograph, a copy to be sent under separate cover to every member of the California Medical Association. Envelopes will be suitably marked to indicate nature of contents, and members of the Association are requested to instruct their office assistants not to throw these reports into the waste basket. The future of medical practice in California, and, to lesser extent, perhaps even in the United States, depends upon full understanding and coöperation in the issues at stake. Therefore, the report of proceedings should be read by all C.M.A. members and placed in their files for future reference.

\* \* \*

**Press Reports on the Proceedings of the C.M.A. House of Delegates.**—As was to be expected, the reports which appeared in California newspapers, and which were broadcast through the national press associations, were of varying nature. Particularly so, since Governor Warren, in addressing the California Legislature at its opening meeting on Monday, January 8th (two

days after the adjournment of the C.M.A. House of Delegates) brought medical care issues to the front, as may be noted in excerpts from his comments on "Prepaid Medical Service":

... "It is my recommendation that you [the California Legislature] take action at this session of the Legislature on a program which will bring adequate medical care to the people of our State, on a prepaid basis. . . .

... "I am convinced that if we are to keep abreast of needs in the services which we afford our people, we must start on this program immediately."

The section of Governor Warren's address to the Legislature relating to "Prepaid Medical Service," appears in this issue, on page 35. All C.M.A. members should take the time to read it, and if possible, also the other items bearing thereon. Better far, for physicians to have clear understanding and orientation from the beginning, than to engage in sharp criticism, misunderstanding and recrimination later on.

The Council of the California Medical Association solicits the prompt advice of component county units, and of all members, both in civilian practice and military service. Communications may be sent to individual Councilors or to the Association Secretary, at 450 Sutter Building, San Francisco (8).

\* \* \*

**What Is Ahead?**—One guess is perhaps as good as another. For, who can tell in advance what the final result will be, depending as it does on the ballots of Assemblymen and State Senators, on so controversial a subject as compulsory health insurance?

According to press reports, Governor Warren will present a bill of his own.

In Los Angeles, before the C.M.A. House of Delegates, representatives of Labor (C.I.O.), stated they would present their own bill. Regarding this, see also in this issue, on pages 32 and 40.

Note may be made that it is possible the California Medical Association may deem it advisable to present a bill of its own, in which would be incorporated the principles and procedures espoused by its members, as understood by its officers.

If the Legislature, now in session, by May of this year, 1945, enacts one or the other of these medical care bills that will be submitted, or a composite thereof, such a measure then would be placed on Governor Warren's desk for approval or veto.

At the December 13th meeting, in answer to a direct question by a Councilor, Governor Warren stated if such a bill was presented to him, and its contents were not too vicious, he felt he would be obliged to attach his signature, giving approval.

However, the present 56th California Legislature can by-pass the proposed bills and through referendum, submit such a measure to the people, for electorate approval. Such approval

would make the law partake of the nature of a constitutional amendment, with all the serious implications involved in constitutional amendments.

Or, the Legislature may take no action other than to appoint an Interim Committee of Senators and Assemblymen to study the entire subject, and bring to the next Legislature, two years hence, a report with perhaps, some recommendations.

Or, one or more of the groups submitting bills to the Legislature, may endeavor, independently, to secure the necessary signatures to place their respective measures on the ballot of the next general election of the State, in November, 1946, for direct initiative vote by the people.

\* \* \*

From the above and what appears on this subject elsewhere in this issue, it should be apparent to all, that, during the coming weeks and months the officers and members of the California Medical Association will be called upon for much serious thinking and action. Let every member stand by his post and, when called on, lend a hand to render all possible aid to support that program and those plans that will insure to the citizens of California adequate medical service of highest quality. Physicians know better than others the conditions that make for high quality of medical service. On the issue of quality of medical service, there can be no compromise. Standards must be preserved and promoted, and plans that would make for lower types of service must be fought to the bitter end.

In conclusion, request is again made that all members read carefully the various items to which reference has been made above.

In due course, other statements and comments will follow.

#### DOCTOR SHORTAGE PAYS OFF

In the past, when great battles were fought, loss of life was multiplied tenfold because of lack of prompt and adequate medical care for the wounded. But in the present war the story has been different. Even yet the full account of the achievements of medicine on "D-Day" has not been impressed upon the country.

One correspondent reports that within forty-five minutes after the first troops landed on the shores of France, a medical unit was on the beachhead picking up casualties, while in the background a landing craft was being converted into an operating theatre.

During the first day, twenty-two major operations were performed by this single unit. From dawn on "D-Day" until four o'clock in the afternoon, the unit remained on the beach. Blood plasma had been landed and transfusions made from mobile equipment.

Fifty thousand American doctors are in the armed forces. Everyone of them is a trained expert at the business of saving lives. At last those civilians who have had to linger in crowded waiting rooms to secure the attention of the overworked doctors on the home front, can see the reason for the inconvenience thrust upon them.—Oakland *Inter City Express*.

Life, to be worthy of a rational being, must always be in progression.

—Samuel Johnson, *Letter to Mrs. Piozzi*.

## EDITORIAL COMMENT†

## SEMLIKI FOREST VIRUS

During the course of a field investigation on the epidemiology of yellow fever, a hitherto unknown neurotropic virus was isolated from mosquitoes by Smithburn<sup>1</sup> and associates of the Yellow Fever Research Institute, Entebbe, Uganda.

About 130 female *Aedes abnormalis* mosquitoes caught in the Semliki Crown Forest were emulsified in 4 c.c. 10 per cent normal human serum and the emulsion filtered through a Seitz EK asbestos pad. Samples (0.03 c.c.) of the resulting filtrate were inoculated intracerebrally into 6 normal adult white mice. All mice remained well till the 27th day when one became paralyzed in the hind legs. This mouse was sacrificed and its brain used for intracerebral inoculation of a second group of 6 mice. All mice of the second group became ill on the 4th day. Four were then sacrificed for subinoculation tests. The other 2 died on the 7th day.

There were still greater increases in virulence on subsequent brain-to-brain passage. By the 160th passage the virus had become so virulent that it caused symptoms within 24 hours after intracerebral inoculation, death usually occurring within 48 hours. It was found that 5 to 20 intracerebral MLD of the passage virus were required to cause death by subcutaneous or intraabdominal inoculation, and from 1,000 to 10,000 MLD to cause death by intranasal instillation. By the 99th mouse passage the virus had acquired a demonstrable intracerebral pathogenicity for guinea pigs and rabbits, but was not sufficiently pathogenic to produce illness upon extraneural inoculation. By the 132nd mouse passage the virus had acquired a demonstrable intracerebral pathogenicity for rhesus monkeys, but was still non-pathogenic for monkeys if given by the subcutaneous route. Given extraneurally the virus stimulates the production of circulating antibodies in guinea pigs, rabbits and monkeys, as shown by serum protection tests on mice. Intracerebral pathogenicity and extraneural antigenicity were also demonstrated with 5 species of wild primates captured in neighboring regions of the Semliki Crown Forest.

The virus can be readily cultivated in the developing chick embryo, and suffers very little loss of potency if dehydrated in the Flosdorff-Mudd apparatus. Ultrafiltration experiments indicate that it is probably the smallest virus thus far discovered. Cross-neutralization tests with specific immune serums have shown that the virus is not identical with any known filterable virus thus far described, with the possible exception of that of

Russian spring-summer encephalitis, not yet tested.

In mice injected intracerebrally the virus appears in the circulating blood in remarkably high concentration long before the onset of symptoms. In one titration of 5 pooled serums from mice still apparently well, 16,500,000 infective units per c.c. were demonstrated by intracerebral tests. After symptoms develop, the brain titer is usually at least 100 times that of the serum titer. The virus is also present in considerable quantities in the heart muscle, lungs, liver, spleen and all other tissues thus far tested. The titer is relatively high in the kidneys, suggesting that the virus is both neurotropic and nephrotropic.

The only constant macroscopic lesion seen at autopsy in mice, guinea pigs, rabbits or monkeys is hyperemia of the brain. In every brain thus far studied minute foci of necrosis and local infiltrations were found, lesions not unlike those described by Watson<sup>2</sup> in equine encephalomyelitis. Minor renal lesions were also present in most animals. All other visceral tissues escaped demonstrable injury.

Serums from 20 species of African wild animals have thus far been tested for the presence of specific antibodies. Humoral immunity was present in 24 of the 65 primates (6 different species) tested, but was not demonstrable in non-primates. Serums from 313 human beings were similarly tested, 47 of whom gave positive reactions. The percentage of positive reactions varied from 7.9 per cent to 32 per cent in different regions, and was usually much higher in adults than in children.

It is not yet apparent that the natural virus causes recognizable illness in man or primates, nor that there are any objective sequelae other than specific antibody production. Mosquito transmission is suspected, though not yet fully established.

P. O. Box 51.

W. H. MANWARING,  
Stanford University.

## REFERENCES

1. Smithburn, K. C., Mahaffy, A. F., and Haddow, A. J., *J. Immunol.*, 49:141, 159 (Sept.), 1944.
2. Watson, D. W., and Smadel, J. E., *Proc. Soc. Exp. Biol. and Med.*, 52:101, 1943.

*Caius Julius Caesar (B. C. 100-44).*—Historical verification that Caesar was an epileptic seems to rest upon the authority of Plutarch and Suetonius. Both speak of repeated attacks, one having occurred just before the battle of Thapsus. Whenever he felt an epileptic seizure coming on, Caesar would try to cover his face. In the opinion of one writer the contemporary bust of Caesar quite plainly indicates the *Facies Epilepticus*, while another says that the iconography of Caesar proves the absence of facial anomalies.—Warner's *Calendar of Medical History*.

A man stricken with tuberculosis is just as much of a loss to the nation for whom he might otherwise be working or fighting as a man blasted with shrapnel.—Lt. Comdr. Emil Bogen, M.C., U.S.N.R., *Amer. Rev. Tbc.*

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

## ORIGINAL ARTICLES

## Scientific and General

## INDUSTRIAL MEDICINE IN WARTIME

FOREWORD AND FORWARD!

OR

## THE WIDENING FIELD OF INDUSTRIAL MEDICINE\*

RUTHERFORD T. JOHNSTONE, M.D.

Los Angeles

"REALLY, what have we here"! exclaims the Oldtimer, as he scans the contents of this particular number of the CALIFORNIA AND WESTERN MEDICINE; for, accustomed to the traditional character of his State Medical Journal, he wonders why Industrial Medicine rates this new recognition. Two or three years ago devoting an entire issue to this subject would not have been considered, reflects the Oldtimer, of whom there are many. Such ruminations are quite correct. However, the exigencies of war induced the publication of four special numbers devoted to wartime medicine, of which this is the last, but not the least important.

What do we have here? New names, new ideas, and different material. Part I has been especially designed to focus attention upon several aspects of Industrial Medicine, of which the profession at large, perhaps, is not fully cognizant or possibly even aware. Part II presents the modern treatment of some long-recognized problems. (For indexes, see pages 6 and 15.)

Actually the war has not altered greatly the practice of Industrial Medicine; its essentials remain unchanged. But the "brazen throat of war" served to proclaim the importance of this facet of medicine first given cognizance by Ramazzini 250 years ago. Today, industrial medicine has reached a level of utility second to no other branch of our profession. Lest there be some who will challenge that statement; who still stigmatize the industrial physician as a "finger-wrapper" or "insurance doctor"; who feel that the practice of industrial medicine requires no special training, and that it can be practiced indifferently with the left hand while the right is devoted to private practice, the following remarks, as well as the contents of this issue, may be illuminating.

Further reflection should make it apparent that there is an immediate need for the inclusion of the subject of Industrial Medicine within our undergraduate teaching, and in our postgraduate courses. Consider, if you will, the type of program presented each year by our county societies. Annually these are repetitious. The writer does not disclaim the importance of heart disease, diabetes, tuberculosis, arthritis, etc.; but the constant rehashing of these subjects, too often by the same speakers year in and year out, is at least discriminatory. This same criticism is applicable to the usual format of our medical periodicals. It is no longer possible for the general practitioner or specialist to escape contact with the occupational disease problem. It may be startling to some to learn that the occupational diseases constitute the largest number of diseases falling into any one subdivision of medicine. It is obligatory, therefore, that a knowledge of these be disseminated to the profession at large. It is

even more essential that those preparing to practice medicine be taught about industrial medicine. It is imperative that our medical schools make room in the curriculum for the adequate teaching of this subject. The urgency awaits the vision and action of our professors.

Long ago Industrial Medicine outgrew its "Safety First" clothes. Preventing or treating the injuries—the traumata resulting from accidents—is now but one phase of an industrial practice. Since World War I new processes have been introduced into industry involving noxious solvents, fumes, dusts, and metals. Nor does there appear to be an end to the wizardry of the chemist or metallurgist when one contemplates the future of the synthetics, plastics and alloys. Few of these processes or the substances involved are free of some danger to the workmen unless adequate protection is supplied. Such protection can be found only in an efficient hygiene program which is one of industry's crying needs today. Medicine must supply industry with trained men and specialized laboratories for this purpose. An insight into this problem is presented in the article by Dr. Hugh Dierker and Paul Brown.

For too many years industrial management has employed a worker upon one basis only—his ability to work. No sensible attempt was made to assign a worker to a job according to his mental and physical capacities. Likewise, medicine has been guilty of consigning to the human scrapheap those who were physically handicapped; we were content with prescribing a sedative for the epileptic, idleness for the cardiac, or a prosthesis for the cripple. Rarely did a physician extend his interest to the point of securing suitable work for his patient. But Industrial Medicine has learned to utilize the handicapped individual, whether the deficiency be congenital or acquired, or as the result of a war wound. Dr. Kuh reveals how management and industrial medicine are matching job requirements with skill characteristics—matching physical demands with individual capacities. It is particularly important to note that the selective-placement technique worked out by Dr. Kuh and his coworkers, is suitable for all workers and does not single out the handicapped person. This is a program to be participated in by the entire profession.

There are still other fields which Industrial Medicine encompasses, as the title of this comment intimates. With America's increasing interest in the social and economic welfare of its masses, it was inevitable that Industrial Medicine would be most intimately concerned. Well-meaning, politically-fostered plans to extend medical care have encouraged a goodly percentage of the people to demand federal medicine. It is this writer's considered opinion that Industrial Medicine offers the best buffer against socialized medicine as proposed by the Wagner Bill, or any subsequent facsimile thereof. It is this phase of medicine which deals most intimately with the very segment of our people, for whom better medical care is being demanded. That an employee, aided by his employer, can provide for himself and family adequate preventive and curative medicine is being demonstrated by many industries. Dr. A. C. Dick, Medical Director of Consolidated Vultee Aircraft Corporation, has given this problem a great deal of study, as shown by his able discussion in this issue.

Within industry there is the greatest opportunity for discovering tuberculosis in the incipient stage, as proved by the surveys conducted by the National Tuberculosis Association, the United States Public Health Association, and the California Tuberculosis Association. There exists an equal opportunity for a venereal disease program, or for a nationwide nutritional, dental, and mental hygiene program. There are still other frontiers, such as the early recognition and correction of defective hearing or vision; of the problems peculiar to old age or sex.

The limitation of editorial space forbids mention of

\* One of several papers in a Symposium on "Industrial Medicine in Wartime—The Widening Field of Industrial Medicine." Papers collected by Rutherford T. Johnstone, M.D.

other worthy contributions to this special number. Suffice it to say that across the horizon of tomorrow awaits the opportunity for organized medicine to create a healthier America; to prevent the recurrence of the situation that found one out of four persons physically or mentally unfit. Since man spends his greatest span of

years either in school or at work, the task of maintaining national optimum health must to a great degree be entrusted to industry and our schools. There is increasing evidence that Industrial Medicine is aware of its opportunity.

423 Towne Avenue.

## PART I

*The Interrelationships of Selective Placement and Rehabilitation*

*How May a Worker Receive Adequate Medical Care?*

*The Epileptic in Industry*

*Tuberculosis in Industry*

*Venereal Disease Control in Industry*

*The Place of Dentistry in Industry*

*The Use of Vitamin Supplements in Industry*

*Control of Toxic Exposures*

*Chart—Treatment of the Acute Occupational Intoxications*

*Treatment of More Common Industrial Injuries*

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Howard W. Haggard, M.D., New Haven, Conn.

Hugh Dierker, M.D., and

Paul G. Brown, Los Angeles

Rutherford T. Johnstone, M.D., Los Angeles

Table

## THE INTER-RELATIONSHIPS OF SELECTIVE PLACEMENT AND REHABILITATION\*

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Oakland

THE increased wartime need for maximal utilization of manpower has created great interest in proper selective placement at work and the forthright rehabilitation of those requiring it. There is, nevertheless, some confusion as to the respective fields covered by placement and rehabilitation, as such, and considerable misuse of terms.

Every worker needs correct placement at work in accordance with his skills and physical capacities. In fact, he needs much more than that. The International Labor Office's recent "Declaration of Philadelphia"<sup>1</sup> advocates that among the nations of the world there be the development of programs which will achieve "the employment of workers in the occupations in which they can have the satisfaction of giving the fullest measure of their skill and attainments, and make their greatest contribution to the common well-being." This point of view emphasizes the value of a selective placement technique which is suitable for all workers, and which does not, as some techniques do, single out handicapped persons.

Only handicapped persons require vocational rehabilitation, which may be defined as a service for creating or recreating earning capacity for all types of physically or mentally handicapped persons through vocational adjustment. Rehabilitation applies to those handicapped persons who cannot return to previous employment, or cannot readily be placed at other available work.<sup>2</sup> In some instances, rehabilitation aims to improve upon a disabled worker's previous earning power.

After a person has been vocationally rehabilitated he will require selective placement at work. To effect selec-

tive placement an evaluation of the physical capacities of any worker, disabled or fully able-bodied, is necessary. It is also necessary to evaluate the physical capacities of any prospective candidate for rehabilitation in order to determine whether he can return to former employment or to any other available job; whether the candidate's condition is relatively stable, and what the prognosis is. Since vocational rehabilitation requires time and expense, only those candidates should be recommended for rehabilitation whose probable length of employment or future earnings at the prospective work will justify the effort.

### WHEN PHYSICAL EVALUATION IS NECESSARY

Evaluation of a worker's physical capacities in respect to a prospective job is, therefore, necessary (1) in originally placing any person at work or in transferring him from one job to another job within the organization; (2) in deciding whether a disabled person can return to a previous job or be placed on another suitable job and, if not, whether vocational rehabilitation for some new job is justified; (3) in planning a person's rehabilitation; and (4) in placing the individual after rehabilitation. Hence, a technique for evaluating the physical capacities of a worker is needed which can be related to the physical demands of a prospective job. Such a technique, known as *Physical Demands and Capacities Analysis*, has been developed at the Permanente Foundation Hospital in conjunction with the regional office of the War Manpower Commission in San Francisco, for the selective placement of Kaiser Shipyard workers at the time of transfer to new shipyard jobs. The technique has been described elsewhere.<sup>3,4,5,6</sup>

In brief, a physical capacities analysis of the worker evaluates what the worker can do in respect to a number of physical factors, such as lifting, carrying, pushing or pulling, and in respect to a number of environmental factors, such as working inside or outside, or working under high or low temperatures. The physical demands analysis of a job evaluates what the job requires in respect to the same physical factors and in respect to the same environmental factors. Hence, a common pattern is used for analyzing both worker and job.

\* One of several papers in a Symposium on "Industrial Medicine in Wartime—the Widening Field of Industrial Medicine." Papers collected by Rutherford T. Johnstone, M. D.  
From the Permanente Foundation Hospital.

The practicing physician, however, wants to know how much can the cardiac lift or under what environmental conditions can he work. Given any diagnosis, how can the physician translate clinical data in terms of physical capacities? That is a pertinent question. At the present time and until more is known concerning the relationship between clinical data and physical capacities, the physician's judgment is probably the best criterion. It is, nevertheless, progress to clarify the problem for, whenever a physician passes upon a man's ability to work at some job, whether the physician is aware of it or not, he is really translating clinical data into a physical capacities analysis.

Experience with the formal technique of physical demands and capacities analysis has found us relying on certain criteria. For example, in the placement of cardiacs the physical examination, electrocardiogram, chest x-ray for heart size, and past history in respect to arduousness of work, are all taken into account. Tabulation of criteria for guidance of staff physicians has been done for hypertensive heart disease, coronary arteriosclerotic heart disease, rheumatic heart disease, syphilitic aortic valvular disease, and congenital heart disease.<sup>7</sup> For rheumatic heart disease, for example, the following criteria apply:

A patient with rheumatic heart disease, because of the rheumatic diathesis, should also avoid wet quarters, sudden temperature changes, and perhaps the night shift.

Previous approaches to the problem of selective placement of handicapped persons at work have resulted chiefly in the preparation of lists of jobs which individuals with specific handicaps can perform, such as jobs for one-armed persons, or in classifications of handicapped people with reference to type of work to be done, as workers who must avoid hazardous machinery. Before these systematic approaches physicians usually recommended work in general terms, such as heavy, moderate, light, sedentary, or no work. Such statements were subject to broad interpretation and to misinterpretation. It is believed that from what has been said, the reader will agree the adoption of the identical pattern for analyzing both worker and job has decided advantages.

#### NATIONAL ADOPTION OF CAPACITIES ANALYSIS

There are already signs of the national adoption of the fundamental principle of employing the same pattern for analyzing worker and job as a selective placement tech-

nique. The Associated Industries of New York State have just published a pamphlet for member companies.<sup>9</sup> The American Mutual Alliance, representing companies engaged nationally in the field of casualty insurance, has published a similar treatise.<sup>10</sup> The Association of Casualty and Surety Executives, representing stock companies, has recently issued a declaration of attitude on the employment of handicapped workers, affirming the philosophy that handicaps are of degree only—*who is without one?*—and that with proper placement nearly all handicaps to employment resolve themselves.<sup>11</sup>

The great interest in rehabilitation and placement means the more effective utilization nationally of all workers—male or female, young or old, emotionally stable or unstable, able-bodied or physically handicapped, and particularly the war disabled. Placement of the veteran, in the final analysis, does not present a problem different from the placement of any other person. His successful placement at work requires due regard for the physical demands of the job, and for the physical and emotional environment. A former machine gunner, who has suffered from an anxiety neurosis, should not be given a job next to a riveter. It is generally agreed, however, that we should not be unduly paternalistic in handling the veteran and that the most important single factor for insuring his employment with safety is selective placement.

Never before has there been such need for the physician to translate effectively clinical data into physical evaluation. Research will be needed to develop new techniques for assisting the physician in this work. There are already indications that such research will be forthcoming. It will be of great value in effecting the proper utilization of manpower.

#### SUMMARY

Only handicapped persons require vocational rehabilitation, but all persons require selective placement at work. Both rehabilitation and selective placement involve physical evaluation. The physician's rôle is to translate clinical data into physical capacities analysis.

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#### REFERENCES

1. The Declaration of Philadelphia, International Labour Office, Montreal, Canada, 1944.
2. A Public Service for Restoring the Handicapped to Useful Employment, Federal Security Agency, Office of Vocational Rehabilitation, Washington, D. C., 1944.

#### WORK RECOMMENDATIONS FOR CARDIAC PATIENTS With Rheumatic Heart Disease

(Illustrative of the Manner All Cardiac Patients Are Handled)

##### Therapeutic Classification\*

##### Class A

Recovered case (Definite history but no diagnostic signs). Apical systolic murmur. No cardiac enlargement or abnormality of contour.

##### Class B

Class I\*\* (No symptoms on ordinary activity). Mitral stenosis with regular rhythm. Slight cardiac enlargement or left auricular prominence. (X-ray diagnosis readily made.) Right axis deviation by EKG.

##### Class C

Class II (Symptoms on ordinary activity). Auricular fibrillation. Well developed mitral stenosis. Aortic stenosis. Moderate cardiac enlargement.

##### Class D

Class III (Symptoms on less than ordinary activity). History of one failure (may be given special consideration if failure was due to active rheumatic myocarditis). Marked cardiac enlargement.

##### Class E

Class IV (Symptoms at rest). Active rheumatic fever (as determined by resting apical rate over 100, persistent leucocytosis, anemia, rapid sedimentation rate, joint pains, or EKG evidence). Left ventricular strain. Aortic regurgitation with history of failure.

##### Work Recommendations No Restrictions.

50 per cent of Normal Activity.

25 per cent of Normal Activity.

Sedentary Work

No Work.

\* The therapeutic classification (A, B, C, D, and E) follows that of the American Heart Association.<sup>8</sup>

\*\* Numerals represent the functional classification of the American Heart Association.<sup>8</sup>

3. Physical Demands and Capacities Analysis, Region XII, War Manpower Commission, Bureau of Manpower Utilization, Division of Occupational Analysis and Manning Tables, San Francisco, California, and Permanente Foundation Hospitals, California, May, 1944. Published by the Permanente Foundation.
4. Kuh, Clifford: Physical Demands and Capacities Analysis, Permanente Foundation Medical Bulletin, 2, 18 (Jan.), 1944, and 2, 88 (Mar.), 1944.
5. Kuh, Clifford: Physical Demands and Capacities Analysis, Permanente Foundation Medical Bulletin, 2, 135 (July), 1944.
6. Kuh, Clifford, and Hanman, Bert: Current Developments Affecting the Physician's Role in Manpower Utilization, Jour. Am. Med. Assn., 125, 165 (May 27), 1944.
7. Levine, Eugene B., Permanente Foundation Hospital, Personal Communication.
8. Nomenclature and Criteria for Diagnosis of Diseases of the Heart, New York Heart Association, 1943.
9. Reemployment of Ex-Service Men and Women, II. Job Analysis for Sound Placement, Associated Industries of New York State, Buffalo, 1944.
10. A Plan to Help You Employ Disabled Veterans and Other Handicapped Persons Productively and Safely, American Mutual Alliance, Chicago, 1944.
11. Declaration of Attitude Concerning the Employment of Disabled War Veterans and Other Disabled Persons, Association of Casualty and Surety Executives, New York, N. Y., 1944.

### HOW MAY A WORKER RECEIVE ADEQUATE MEDICAL CARE?\*

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IS it necessary to consider the problem of medical care for a worker as being different from that for other persons? A worker is a member of a community in the same sense as other members of his family or any other individual, whether or not he produces goods or services for which he receives pay from the management of a plant or facility. In this sense there is no reason for considering that medical care for a worker should differ from that available to other members of his community.

There are several factors, however, with which a worker must contend that do differentiate him from other members of his community. When he loses time from his job, through illness or injury, he loses income for himself and those who depend upon him. Furthermore, his absence from his job constitutes an economic loss to his employer. Thus, industry, as well as the community, has an interest in proper medical care for workers. For this reason, it is proper to consider medical care for workers as a specialized problem.

#### WHAT IS AVAILABLE?

What is available for a worker in the way of medical care? In a large factory or industry there is usually a management-controlled medical or first aid department for the care of occupational injuries and diseases. Rules and regulations promulgated by the insurance carriers and by the State agencies supervising industrial hygiene, tend to standardize the quality of care in a large industry to the acceptable minimum.

Under the supervision of an experienced full-time Industrial physician, the occupational hazards of workers are, as a rule, very well cared for. Because of the many factors involved in industrial medical care, a part-time physician cannot satisfactorily fulfill his obligation either to the worker or to management. If the industrial physician in a plant is there part time because he has several small industries to care for, and if this type of work is all he does, and if he has properly trained nurses on his staff, he can give the worker adequate occupational medical care.

The physician who is in private practice and merely "takes on a little industrial work" to supplement his

income (and I know of not many who do so for any other reason) is a menace to Industrial Medicine, for his interest is not in it. He does not comprehend the problems of factory work, nor does he choose to soil either his clothes or his mind in the study of these problems, first-hand.

The proper care of occupational injuries and illnesses begins first with their prevention. Then there must be the proper first-treatment. Following this, the decision must be made whether or not the condition is occupational, then if it is compensable, then if time away from the job should be ordered or a transfer to a different job. Next, the proper time of return to work must be judged, and whether to the same or to a different job. An honest evaluation of disability must be made and finally a follow-up to ascertain the accuracy and effectiveness of diagnosis, treatment, disability evaluation, rehabilitation and proper placement. Analysis must be made of the circumstances surrounding the accident or illness, to the end that a repetition may be avoided. Records must be established and maintained for management, insurance carriers and state agencies, and these must be filed for reference until the Statute of Limitation expires.

Unless these minimum requirements for occupational conditions are observed, the worker is not receiving adequate industrial medical care. These things he must have, because he is not only a member of the community, but an economic factor in integrated production. Collectively, workers represent millions of man-hours, and when they are ill or injured, billions of dollars are lost to employees and management alike.

So far, we have discussed only the in-plant care for workers suffering occupational injuries or illnesses. Why this is a specialized job for a medical supervisor is obvious.

#### CARE OTHER THAN IN-PLANT SUPERVISION

What of the fact that 90 per cent or more of conditions which affect a worker's efficiency occur outside and away from the plant? Does this imply that the industrial physician should look beyond the plant to see that proper medical care is supplied the worker for nonoccupational conditions because of their effect upon his occupational efficiency? If he does so, he has the following choices:

1. To extend medical care through having a full-time staff employed by management take over complete medical supervision of the worker. This can be paid for by management, the worker, or both.

2. To extend this care still further to take in the worker's family, and thus achieve a maximum feeling of security from economic loss on the part of the worker.

3. To provide group insurance for workers so they may have partial reimbursement for loss of time and a freer choice of physician. There is one definite drawback to the average group insurance policy, in that most companies will pay bills rendered by any practitioner, whether an M. D. or otherwise, and there is justifiable doubt that this constitutes adequate medical care.

4. The industrial physician can utilize for his workers the services of such groups as the Blue Cross, the C. P. S., and others. This ideally should be supplemented by a personal knowledge on the part of the co-operating physicians outside of the plant of general conditions within the plant. Certainly, when these outside physicians suggest changes in conditions of work, these should be discussed first with the industrial physician.

5. The industrial physician can work out a policy with the reputable members of the regular local medical society for the care of all nonindustrial conditions which affect his workers' efficiency. These "outside" doctors will then constitute an extension of the plant medical staff, or the plant medical staff can be considered an extension of the community medical group specializing

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in in-plant medical care, and the two groups can work in harmony to the same end. Any form of group insurance can be utilized to assist in the payment for this service.

All of these and many more possible methods have been utilized. Some have been very successful, others not.

#### INDUSTRIAL MEDICINE AS A SPECIALTY

One thing, however, is certain. Industry has become so integrated, and rules, regulations, and laws concerning workers have become so fixed that the industrial worker is, and will continue to be, a specialized problem no matter what his status when he is away from industry.

Thus, it seems apparent—gnashing of teeth to the contrary notwithstanding—that the general practitioner who “takes on a little industrial work” and his brother who is a “part-time industrial man” are one with the dinosaurs and dodos.

Recent scandals, such as occurred in New York City when many doctors were removed from insurance company rôles for fraud, could have come about as a result of insufficient industrial medico-legal knowledge on the part of “part-time doctors,” as well as from lack of scruples. No matter what the reason, such incidents will not be overlooked by the lay reformers who would regiment and control medical practice.

The medical profession must recognize Industrial Medicine as a very real specialty which has developed as a corollary to changing economic and social conditions.

The medical profession must develop and train specialists for this work, and accept the leadership in development of proper programs for the care of workers, or we will play directly into the hands of other factions whose whole interest is not the providing of good medicine.

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### THE EPILEPTIC IN INDUSTRY\*

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**A**PPROXIMATELY a third of a million American men and women of working age are subject to seizures. Probably a quarter of a million of these are fully able to work, but, even in these man-power hungry days, many are deprived of this privilege and the nation is deprived of their labor. The reasons are two: Public prejudice and laws regarding compensation.

Statement that the great majority of noninstitutionalized epileptics are fully capable of productive work is supported by information concerning more than a thousand private or clinic patients who were questioned and examined by neurologists throughout the country.<sup>1</sup> Examination disclosed that the vital organs and the musculature of these patients were as sound as in any unselected sample of the population; approximately nine-tenths had normal muscular strength and control, and in only 9 per cent was there gross mental deterioration. At the time of examination only 21 per cent were listed as unable to work, and of these, 85 per cent blamed seizures for the disability. Of those who reported they were fully able to work, 88 per cent were employed at the time of the survey. As for occupations, 14 per cent of the men were clergymen, dentists, engineers, lawyers, teachers, or physicians. Most frequently-named occupations were salesmen, 14 per cent; farmers, 13 per cent;

clerks, 10 per cent; laborers, 10 per cent; and mechanics, 6 per cent. Many patients were employed in positions in which a sudden loss of consciousness would endanger life or property.

For epileptics, as for healthy persons, the proportion of accidental fatalities which are occupational is a rough indication of the degree of danger in a given employment. Among industrial policy holders of the Metropolitan Life Insurance Company<sup>2</sup> only 24 per cent of deaths due to accident occurred when the workman was “on the job.” The proportion was lowest (1.8 per cent) for clothing-workers, and rose progressively for waiters, shoe and cotton mill operators, store clerks, hotel servants, office assistants, automobile factory operators (the last 6 per cent), farm and unskilled laborers (22 per cent), mechanics (28 per cent), chauffeurs (44 per cent), structural iron workers (67 per cent) and, highest on the list, electric light and power linemen (86 per cent). The great majority of occupations should be open to epileptics if the person is fitted to the job, and if certain general needs are met.

#### WHAT IS NEEDED

1. The first need is for a better knowledge of epilepsy on the part of the public. Employers and fellow employees must understand that individual situations differ widely. Seizures vary in severity from a blinking of the eyelids to a generalized convulsion, and in frequency from once in a lifetime to many a day. Except for their occasional lapses of consciousness and muscular control, most epileptics are as normal as their well brothers or sisters, and usually more eager to work and prove their value. Seizures are less likely to occur when the person is working than when he is idle. Finally, the recent discovery of new methods of diagnosis and of non-sedative drug therapy has greatly increased the physician's ability to assess the seriousness of the case, and to rid the patient of seizures.

2. The second need is for open-eyed coöperation between employer, patient, and doctor. At present, the patient must conceal his malady, a need often frustrated by the 4-F draft classification. A disability, which is hidden from the employer, prevents proper placement or the taking of needed precautions.

3. A third, and immediate need, is the clarification of labor compensation laws. Apparently, there are no statistics which show that the accident rate for epileptics is higher than for nonepileptics. One competent authority believes that if the epileptic is properly placed, his accident rate is not abnormally high.<sup>3</sup> The Civil Service enrolls epileptics, if the condition is not severe and seizures are under medical control. Probably, epileptics have a better accident experience than alcoholics or the chronically careless. However, known epileptics are usually refused employment in industry because of the liability of the employer for any accident which may occur. As to whether the employer is liable for injury which arises out of the person's disability, and not out of his employment, court decisions have not been in agreement. It would seem that either the epileptic should be permitted to waive his rights to compensation for injuries resulting from a spontaneous seizure (a provision in the compensation laws of only two States), or else insurance companies (and hence industry and the public) should pay the increased costs, if any, for compensation of these (presumably) handicapped workers.

This problem of compensation applies to all physically-handicapped workmen and not simply to epileptics. The issue is sure to “come to a head” with the program for the rehabilitation of sick and wounded service men. The public will demand that these men have a chance for employment equal to that of the unwounded. The man, who has seizures as a result of brain injury, should have as good an opportunity for work as the man who has lost a

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hand or an eye. In 1940, epilepsy, next to dementia praecox, was the most frequent medical cause for discharge from the Army. War injuries will swell the numbers. Many State Bureaus of Rehabilitation are forbidden to aid in the training of epileptics on the grounds that they are unemployable. Let us hope that this foul idea will not seep into the plans for the rehabilitation of wounded service men.

As discussed elsewhere,<sup>1,4</sup> an enlightened public is a prerequisite to an intelligent handling of this problem. The American Epilepsy League is a valuable agency in public education. Physicians need to be more acutely aware of recent advances in the study and treatment of seizures, and of the therapeutic value of keeping a patient at work.

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#### REFERENCES

1. Lennox, W. G., and Cobb, S.: Employment of Epileptics. *Industrial Med.*, 11:571-574, December, 1942.
2. *Statistical Bulletin*, p. 9, June, 1943.
3. Pillsbury, W. H., of the United States Employees' Compensation Commission. Personal communication to the author.
4. Lennox, W. G.: *Science and Seizures: New Light on Epilepsy and Migraine*, Harper and Brothers, New York, 1941.

## TUBERCULOSIS IN INDUSTRY\*

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WHEN tuberculosis is not diagnosed until the patient is aware of symptoms severe enough to send him to the doctor, the disease is usually moderately or far advanced. Industrial surveys done through the use of miniature x-rays taken by the tuberculosis associations have proven that if tuberculosis is to be discovered in the early and most curable stages, it must be done through the use of mass surveys and routine x-rays of population.

There are two points to be considered in discussing tuberculosis as an industrial hazard. One must be exposed to an open case, and infected, in order to contract the disease, or working conditions must be such as to aggravate a preëxisting infection. In the first group are those who are working in health, such as hospital employees, who are exposed to tuberculosis, particularly in general hospitals where they are in contact with unrecognized cases and no precautions are taken to protect them. (Tuberculosis wards, while a recognized hazard, now use a strict technique). In the same group are those who are exposed in industry through fellow workmen who are open cases of tuberculosis. This is the most important group and by far the largest. The second group includes those who have had preëxisting disease, and work under conditions which aggravate this to the point of reactivation. (In such instances it is not the type of occupation *per se* which is apt to cause the reactivation, but rather the imposition of a long work day, a long work week, inadequate rest, and insufficient nourishment to sustain the required energy output. Statistics and experience reveal few instances where an occupational environment itself causes the onset of reactivation of tuberculosis.) Many of these cases could be prevented if physicians would use sputum cultures and better laboratory work as a criteria for permitting convalescent patients to return to work; or would show sufficient interest in each individual case to advise the worker and cooperate with his employer in the selection of a suitable occupation.

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One possible means of eliminating tuberculosis would be to x-ray the entire population of a given area at yearly intervals for five years, at the same time isolating and treating all communicable cases. The general practitioner and the radiologist can do much toward this.

Paralleling the case-finding work done through x-rays in the induction centers, the tuberculosis associations throughout the country have been working in industries. X-ray units permitting both 4" x 5" and 35 millimeter photographs of the fluoroscopic images of chests have been mounted in trucks and taken into industrial plants and housing units where there were no plant x-rays available, and, as a demonstration project, thousands of workers have been filmed. Demonstrable evidence of pulmonary tuberculosis has been found in from 1 to 5 per cent in the individuals x-rayed by this method, the average running about 3 per cent in most places. About one-half of these were found, on follow-up, to be active cases. These same surveys have uncovered a high percentage of cardiac cases which were undiagnosed prior to this examination.

The policy has been to notify the employee that there are abnormal findings in his chest, and suggest that he consult a physician and arrange for a 14 x 17 film to be taken. The need for better diagnostic work has been shown with a large number of persons who, after receiving the letter advising them to go to their physician, did so and were told that there was nothing wrong, and then subsequent laboratory examinations of the sputum revealed tubercle bacilli! This would indicate that more thought should be given to the proper handling of these survey cases; that less indifference and better coöperation should be exhibited by the family physician, and that communicable cases should be isolated.

There were 56,178 deaths from tuberculosis in the United States in 1943, of which California furnished 3,878, and 7,869 new cases were reported, averaging two new cases for each death. With a high percentage of these cases occurring in industry, it will take the coöperation of the private physician, the plant medical department, the volunteer agencies, as well as the local and State health departments, before this hazard can be controlled. Industry and our schools afford an excellent opportunity for mass surveys which, if combined with a proper follow-up system, will greatly reduce the incidence of tuberculosis in America.

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## VENEREAL DISEASE CONTROL IN INDUSTRY\*

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AN industrial group presents an admirable opportunity for the control of communicable diseases in a substantial adult population. This is as true of the venereal diseases as it is of tuberculosis, smallpox, the common cold, or any other communicable disease.

The venereal disease problem in occupational groups is no greater than it is for the general public. Substantially, employed groups and their families represent, or rather are, the general public. Public health agencies have in the past directed their attentions to school groups because in such is an already prepared, homogeneous group to which mass case-finding surveys and educational programs can be applied. The same is true of an employee

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group in the approach to adults, and this fact is becoming increasingly appreciated by public health agencies.

The venereal diseases cannot be considered occupational or compensable diseases, except as medical and clinical personnel may contract them from handling patients. Industry, therefore, has little direct responsibility for their control, although it has a definite interest and stake in the problem. When it is realized that 90 per cent of all lost time in industry due to illness and injury is from non-occupational causes, and that venereal diseases will be found in about 3 per cent of the workers—in some racial groups the percentage may be as high as 10, 15, or 20 per cent—industry is concerned from the point of view of effect on production.

Many public-health agencies have, in the last few years, seized the opportunity which industry presents, and have conducted mass serological case-finding surveys among industrial workers. These have brought to light many latent syphilis cases, and a few acute cases, and have, therefore, proved their worth.

On a single survey it is worthwhile to find a number of cases among a group of employees; but from a preventive medical point of view much is left undone unless a continuing program is established. There is always a labor turnover and, especially at the present time this turnover is very great. In a very short time the results of the survey will mean nothing as an indication of the situation regarding venereal diseases in that particular plant population.

#### A CONTINUED PROGRAM NEEDED

A continuous program must be maintained by the plant medical service, and this can best be done by coöperation of the plant medical service with the community health agencies.

A program in an industrial plant involves:

1. Close coöperation with local and State venereal disease or health agencies;
  2. Serological and other indicated examinations or tests to be made at the time of employment as a part of a pre-placement physical examination;
  3. Similar examinations and tests as a part of the periodic physical examination;
  4. Refer the infected individual to a private physician or a public clinic for adequate treatment (time off should be allowed if necessary for the patient to go for treatment);
  5. Report the cases found to the public health authorities for follow-up of possible contacts, to prevent further spread;
  6. Careful follow-up of the individual case by the industrial medical department to assure adequate and consistent treatment;
  7. Judicious supervision of placement of the patient undergoing treatment by the industrial medical department. (All employees who are found to have venereal diseases must not be discharged or refused employment).
  8. Education of the workers on the venereal diseases by personal interview in the plant medical department, and also through an organized educational program.
- This education should include knowledge on how the diseases are acquired, how they may be prevented, the effects of the diseases in early and late stages if treated or untreated, and the economic factors involved.

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Tuberculosis is not always a poor man's disease, but savings of a considerable amount which a few may possess at the beginning of their illness are expended in most instances long before the course of treatment is finished.—*The Modern Attack on Tuberculosis* by H. D. Chadwick, M.D., and A. S. Pope, M.D., 1942.

## THE PLACE OF DENTISTRY IN INDUSTRY\*

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DENTISTRY has long been aware of its inseparable part in the overall health service of the individual, and in order that it may assume its share of responsibility in the health field, it is first necessary that Medicine recognize the entire problem. This is particularly true of health service in industry, since such service is administered by the medical profession, and rightly so. However, until the present war, when the necessity of having every man, woman, and youth constantly on the job, very few industries utilized a dental program.

Until two years ago the American Dental Association assigned the problems of Industrial Dentistry to several committees, particularly the Economics Committee. However, at that time, under the Council on Dental Health, an Industrial Committee was established. It is composed of four dentists with knowledge or interest in industrial dentistry, and a consultant, Carl Peterson, M.D., Secretary of the Council on Industrial Health of the American Medical Association. Last year, the chairman of this newly-formed committee was invited to attend the annual meeting of the Council on Industrial Health of the American Medical Association, in Chicago. This is a big step, and indicates the growing tendency to recognize Dentistry in our industrial health programs.

The justification for a dental program in industry is apparent. We know that most absenteeism is of nonoccupational origin. Also, the greater portion of both occupational and nonoccupational absenteeism is complicated and aggravated by dental disease. Estimates of percentages of those suffering from tooth infection, gum infection or both among adult employee groups, run from 65 to 95 per cent.

Whenever a complete health service, dental and medical, exists in an industry, conclusive proof is available to show that, by controlling dental infection, a material reduction in all lost time results. This experience should impress the industrial executive with the fact that an industrial dental program is an economic measure, and an important factor in efficient production.

In a recent study made by Dr. Ernest Sloman, Dean of the Dental School of the Physicians and Surgeons College, San Francisco, he has shown that, throughout the United States, dental care costs 26 cents of each dollar spent for health. It is hard to conceive any complete health care plan that could ignore these facts. If only 25 per cent of our people are getting dental care, and this is costing approximately 25 per cent of each dollar spent on health, how can a medical department in industry function without a dental department?

More emphasis must be placed upon oral hygiene in the preplacement (preemployment) and periodic examinations of all workmen. Furthermore, it should be an efficient examination. Dental examinations made with tongue blades have been proven valueless. In fact, the dental profession now recognizes that the only worthwhile examination is one in which x-ray, mouth mirror, and probe have been used. Therefore, it follows that a dental division of the medical department must not only be manned by a dentist, but he must have proper equipment to function effectively.

An eastern war plant has undertaken a survey to establish the relationship of a good dental health program to the general health and efficiency of its workers, and the

\* One of several papers in a Symposium on "Industrial Medicine in Wartime—the Widening Field of Industrial Medicine." Papers collected by Rutherford T. Johnstone, M. D.

reduction of absenteeism. To date, the findings are astounding, and when the completed results are made public, they will serve further to emphasize that when Industrial Medicine includes Industrial Dentistry, then it may be truly designated as Industrial Health.

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## THE USE OF VITAMIN SUPPLEMENTS IN INDUSTRY\*

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THERE is today, among the leaders in the field of nutrition, general agreement that a considerable portion of our industrial workers are inadequately nourished for best health and mental and physical efficiency. Health and efficiency take on particular significance when industrial production is a critical factor in winning the war. Consequently, nutrition is often translated into terms of production. Certain leaders<sup>1,2</sup> in the field of nutrition believe that improvement in the nutritional status of industrial workers would, in time, result in increased production and efficiency, and diminished absenteeism, spoilage and accidents.

There is no doubt that dietary deficiencies exist, and that their correction would improve the health and vigor of many employees. But the direct translation of health and vigor into terms of production may not always be justified. Improvement in production from better nutrition has, as its premise, that the actual output of the individual worker is a valid measure of his capabilities. Good nutrition, however, does not compensate for bad management; and absenteeism due to poor morale is not corrected by vitamins.

In those plants in which the war effort is pursued to the full capability of the workers, nutritional improvement should have its effect on production, spoilage, accidents, and absenteeism. Even as small an increase in immediate production as one, two, or three per cent is significant,<sup>3</sup> and justifies any effort to obtain it.

The inadequacy of diet best recognized in the present state of knowledge as affecting industrial efficiency is that of certain vitamins. It would seem logical, therefore, as a wartime expedient, to make available to employees suitably-selected vitamin concentrates as dietary supplements. This seemingly logical practice, however, at once meets an opposition among the leaders in the field of nutrition as nearly concerted as the agreement of the need for better nutrition.<sup>4,5</sup> The weight of this authority has undoubtedly discouraged many industrial physicians from recommending such supplementation. In this connection, it is well to inquire as to the reasons for the opposition. Those given in published statements are mainly the following:

1. That the administration of concentrates is a form of therapy, and when given indiscriminately constitutes medical treatment without diagnosis. The fallacies of this argument are:

First, the nutritional inadequacies important in industry are mainly subclinical, and industrial conditions would prevent the routine and necessarily periodic use of individual diagnostic measures even if they were available—and they are not.

Second, that the use of supplements may be considered from the viewpoint of preventive medicine, as in the administration of table salt to workers in hot industries, a

dietary correction which could also be made by altering the food habits of the employees.

2. That the promotion of vitamins is on a very low ethical plane and is, therefore, to be shunned by the reputable physician. The lack of ethics in some instances is certainly deplorable, but only the inhabitant of a scientific "ivory tower" would decline to join the war effort because the company was bad.

3. There are two cogent criticisms against the use of vitamin supplements, and both stem from the same philosophy. One of the most concise statements of these is that of L. H. Maynard<sup>6</sup>:

"While I would agree that the making available of synthetic vitamins to workers in war industries should be of some benefit in many instances, I do not favor such a program, mainly for two reasons. In the first place, it represents a very inadequate and incomplete nutritional program in terms of the needs of these workers. Second, it tends to over-emphasize the contribution to nutrition and health which can be made by a few vitamins, and to cause both management and workers to give less attention to the many other essential components of an adequate diet, with possible detrimental effects in terms of nutrition as a whole."

The industrial physician, faced with the problem of deciding whether or not the employees under his care should receive vitamin supplements, must make his decision as to whether the advantage of possible increase in production justifies the disadvantage of a possible delay in an educational effort. There are some who believe that winning the war on the production front justifies sacrifices even greater than the delay in education; there are others who believe that ultimate improvement is more advantageous than immediate production; and there are still others who believe that there is a middle ground in that the use of vitamin supplements and education are not mutually exclusive—that the supplements may be administered to correct possible existing deficiencies, and then curtailed and finally stopped as education progresses and reaches completion.

The present author is not as optimistic about the speed of this education as are many of the leaders in the field of nutrition who perhaps have had more laboratory than industrial experience. Education could have gone on before the war; it can go on during the war; and it should go on after the war. But it will be a slow progress at best and the important requirement now is winning the war.

The difficulties of education are perhaps no better summed up than in the situation of white bread. For a generation nutritionists have preached the advantages of whole wheat bread—but white bread continues in overwhelming public favor. Faced by the failure of education it was finally decided to fortify white bread with thiamin. Fortification is simply an euphemism for indiscriminate administration.

The wife of the industrial worker and the boarding-housekeeper have not, by and large, learned how to prepare a meal satisfying nutritional requirements or to prevent the loss of nutrients by standing, as on the steam table. Their education may be as slow as that of the public in favor of whole wheat bread, and it would seem equally justified to make up for the deficiency in the diet they supply by reinforcement—reinforcement in this instance by the administration of vitamin supplements to the employees.

There is another way of supplying certain vitamins—and one that is largely approved by many leaders in nutrition.<sup>5</sup> It consists in supplying a well-balanced meal in the factory cafeteria, and further reinforcing the food with one of the best sources of the vitamin B complex—brewer's yeast. This, in spite of the approval it has received, its general desirability and the fact that yeast is a

\* One of several papers in a Symposium on "Industrial Medicine in Wartime—the Widening Field of Industrial Medicine." Papers collected by Rutherford T. Johnstone, M. D.

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natural food substance, is only another way of indiscriminate administration of vitamins—for which the present writer sees no need for euphemism.

At best, the industrial physician should not expect miracles of production from vitamin feeding. In an earlier paragraph, I have indicated the obstacles sometimes imposed by management and other factors. Experiment in determining the effects of such supplements can be made only under difficulties, and the results must be interpreted with caution. I have reported one such experiment<sup>3</sup> that unavoidably leaves much to be desired for complete scientific control. The results of six weeks of administration showed a moderate increase in production, a moderate decrease in absenteeism, and a marked decrease in spoilage. About half of the employees reported subjective improvement. In other plants where the nutrition level was higher or lower, the differences might be correspondingly smaller or greater. And in one where the morale of the employees and the policies of management were unsatisfactory, there might be no effect whatever except the subjective.

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#### REFERENCES

1. Sebrell, W. H., J. Amer. Med. Assoc., 123, 287, 1943.
2. Bing, F. C., J. Amer. Med. Assoc., 121, 813, 1943.
3. Haggard, H. W., J. Indust. Hyg. Toxicol., 24, 332, 1942.
4. Council on Foods and Nutrition, J. Amer. Med. Assoc., 118, 618, 1942.
5. Report of the New York State Joint Legislative Committee on Nutrition, Legislative Document No. 64, 1943, Albany, N. Y.

## CONTROL OF TOXIC EXPOSURES\*

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**B**ASICALLY, the prevention of occupational diseases is a problem of air hygiene. Of the three portals of entry of toxic substances,—namely, skin, digestive tract and respiratory tract,—the last is the one of major significance. It is true that the industrial dermatoses bulk largest in the occupational disease picture, and that some few substances may be absorbed through the skin to cause systemic poisoning. Further, in large-enough doses, some materials are absorbed in dangerous concentration from the digestive tract. But those toxic materials entering the respiratory tract in the form of dust, fume, mist, vapor or gas, are absorbed into the circulation in a disconcertingly efficient manner.

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Let us say that a concentration of 500 parts of carbon tetrachloride per million parts of air (maximum allowable concentration—100 PPM) is discovered by appropriate sampling methods in a given work-room atmosphere.

It then becomes necessary for a team of physicians, engineers and chemists to reduce the concentration to a safe level or to substitute a harmless chemical.

As in the treatment of patients, so in the management of a plant, the remedy must be suited to the individual problem. The method employed must be consistent with the production pattern, available materials, and a number of other considerations. However, there are basic principles which are applicable in all cases.

#### PRINCIPLES INVOLVED

The principles are as follows, in the order of their importance and practical application:

1. *Substitution* of a nontoxic or less toxic substance for the toxic one; e.g., the use of Stoddard's solvent rather than benzol in certain steps of rubber fabrication. This control measure is fool-proof. But production demands frequently preclude the application of this principle, and therefore we must resort to

2. *Isolation* of the process. This may be accomplished in one of three ways:

a. Geographically: by removing the process, from a shop where many workers are exposed to an isolated place on the grounds where few or no workers are exposed.

b. Chronologically: as in the case of some foundries, where it is the practice to have the small "shake-out" crews come in after the majority of the workers doing pouring and molding are gone for the day.

c. Enclosure: by actually building an enclosed space around the dangerous process and preventing the escape of noxious material into the workroom air.

Here again production demands may be such that they do not permit of such practices, and we must rely on

3. *Dilution or General Ventilation*. In other words, if 600 PPM of trichlorethylene are present in the worker's breathing atmosphere, and enough air can be brought in and thoroughly mixed at the breathing zone to dilute the concentration to a point below 200 PPM, the desired objective is accomplished. If it works, this is one of the best control procedures; but there are so many variables in the picture that it is usually more practical to install

4. *Local Exhaust Ventilation*. This is truly a subject in itself, and expert guidance must be sought to apply it in a practical and efficient manner. It is well known that exhaust orifices have no "reaching out" effect to entrap the material in question. The fact is, that only one duct diameter away from the orifice the velocity drops to 7

(Concluded on Page 24)

TABLE 1.—Reference Chart Concerning Basic Exposures

RESPIRATOR	HAZARD					DRAWBACKS
	DUST	FUMES	MISTS	VAPORS	GASES	
Dust (Filter)	*		*			Offer resistance to breathing.
Fume (Filter)		*				Offer resistance to breathing.
Chemical cartridge (Activated charcoal, etc.)				X	X	Low capacity. Rely on sense of smell as index to change cartridge.
Supplied air respirator (Face or helmet)	X	X	X	*	*	Cannot move around freely because of hose.
Gas mask with canister				X	X	Cumbersome. Use only in emergencies.
Oxygen breathing apparatus	X	X	X	X	X	Only for emergencies in which gas mask is inadequate.

\* Most desirable. X Desirable.

NOTE:—Use only the makes of respirators which are approved by the U. S. Bureau of Mines.

TABLE 1.—Treatment of the More Common Industrial Emergencies\*

[illegible]

PREPARED BY RUTHERFORD T. JOHNSTONE, M. D.

## PART II

*Sciatic Syndrome of Traumatic Origin**New Concepts in the Therapy of Industrial Contact Dermatitis**Emergency Treatment of Head Injuries**Industrial Urologic Injuries**The Treatment of Soft-Tissue Injuries to the Hand**Hand Fractures in Industry**Industrial Treatment of Eye Injuries**Burns*

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## SCIATIC SYNDROME OF TRAUMATIC ORIGIN\*

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A DISCUSSION of the sciatic syndrome requires clearer understanding of the phenomena covered by the term "sciatica." Such pain may result from disease of any of the nerve trunks supplying the lower extremities, or involving the spinal radicles: for instance, spinal root compression from herniation of the nucleus pulposus in the lumbar region, neoplasm in the lower spinal canal, malignant or infectious disease of the pelvic organs. Pathognomic analysis reveals that the symptom of pain, seemingly identical in a number of diseases, varies considerably in character as well as in distribution, according to the difference of its traumatic origin.

## HERNIATION OF THE NUCLEUS PULPOSUS

After rupturing through the annulus fibrosus, the nucleus pulposus tends to extrude until it reaches the proximal spinal root. Such contact produces pain in the area of the back supplied by the affected nerve, and pain referred to the lower extremities. In most cases a single spinal root is compressed, and the pain following the anatomic distribution of the nerve is never bilateral.

Infectious, or malignant diseases involve a number of nerve roots; the pain is generally centered in several body segments, widely distributed, as it is referred to the lower extremities, and tends to be bilateral.

Inconsequential back strains often prove the ultimate cause of posterior herniations of the nucleus pulposus. Mostly, these lesions originate from the fourth or fifth lumbar interspace. As the fifth lumbar spinal root traverses the fourth lumbar interspace, and the first sacral spinal root the fifth lumbar interspace, the fifth lumbar and first sacral spinal roots respectively will be involved by such a lesion. Occasionally, they are encountered at higher levels, even in the cervical region whence the pain radiates into the upper extremities.

Diagnosis of herniation of the nucleus pulposus is based on certain well-defined neurological symptoms:

1. Tenderness to pressure over the affected interspace is common, often producing pain throughout the body segment supplied by the nerve whose root has been involved.

2. Limitation of the ability to raise the leg straight, on the affected side, combined with positive Lasègue's sign, will appear in most cases.

3. Careful search will always reveal at least minimal traces of local atrophy of the gluteal and calf muscles.

4. In almost half the cases sensory changes appear, consisting in impairment of sensibility to pain and temperature in the affected dermatome.

5. Scoliosis is common, especially in acute cases, tending to bend away from the side of lesion.

6. The Achilles tendon reflex is lost when herniation of the nucleus pulposus at the fifth lumbar interspace involves the first sacral spinal root. When the fifth lumbar spinal root is involved from herniation at the fourth lumbar interspace, the Achilles tendon reflex is ordinarily not affected, though occasionally slightly reduced.

The clinical diagnosis can, therefore, be based on objective as well as subjective symptomatology, especially on observation of character, distribution and changing intensity of pain. The main characteristic is anatomic distribution of pain, combined with evidence of impairment of nerve root function, apparent in atrophy of the gluteal and calf muscles. In impaired nerve-root function, contraction of these muscles reveals flaccidity in the gluteal cone and in the calf muscles. Frequently, fascicular twitching is observed in the area of atrophy.

Sensory changes restricted to the involved dermatome, pain caused by pressure upon the affected lumbar interspace, combined with the enumerated signs, are sufficient for a diagnosis of the lesion.

Laboratory tests have not proved especially helpful in arriving at a diagnosis. In more acute cases a slight increase in the overall protein content of the spinal fluid may be obtained, amounting to an average of 70 to 80 mg.; otherwise the spinal fluid shows no abnormal changes. But the rise in protein content is not diagnostic.

Myelography reveals herniation of the nucleus pulposus with a high degree of accuracy.

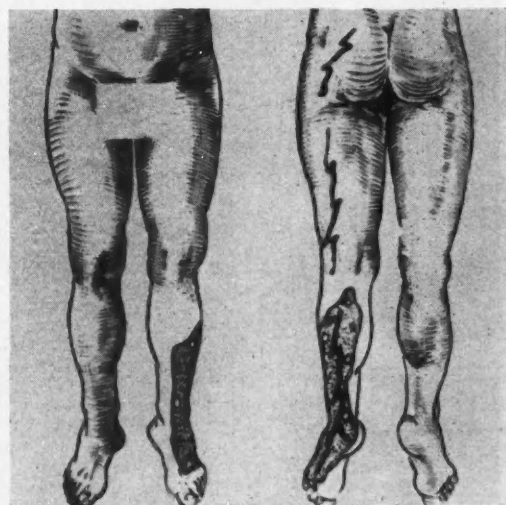


Fig. 1.—Jagged line and shaded area indicate general distribution of pain resulting from simultaneous compression of fifth lumbar and first sacral spinal roots, in ruptures of the intervertebral disk combined with herniation of the nucleus pulposus.

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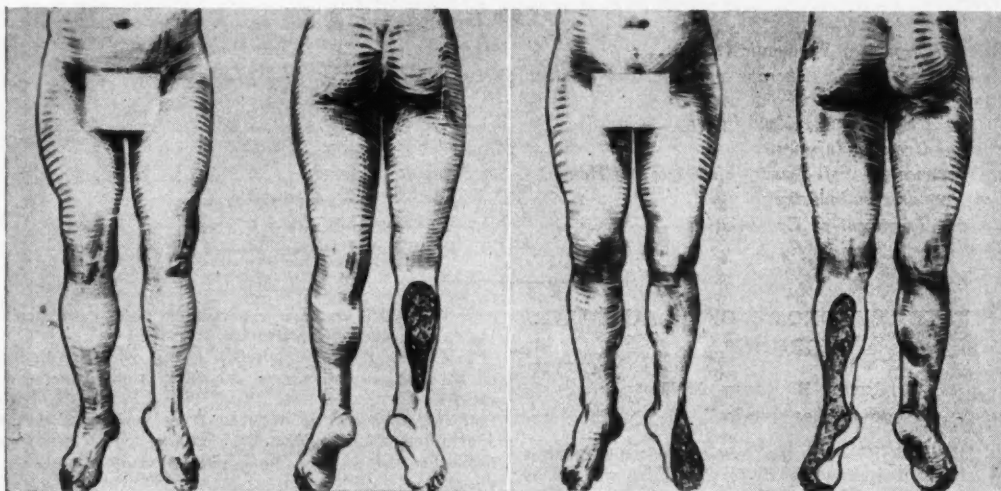


Fig. 2.—Shaded area indicates zone of sensory loss encountered in compression of the fifth lumbar spinal root. Sensibility to pain and temperature is diminished, other forms of sensation within the zone remain unaffected.

Yet, this roentgenographic procedure should be restricted to cases in which not all clinical manifestations can be ascertained and, therefore, clinical diagnosis remains inconclusive. Inflammatory processes in the region of the spinal canal may be aggravated under influence of the available contrast media. Through careful clinical observation, such chronic inflammatory conditions may be recognized, as they differ clinically from the syndrome of ruptured intervertebral disk.

#### TRAUMA TO THE ANNULUS FIBROSUS

Trauma without extrusion of the disk occurs frequently, as a result of strain to the back. It gives rise to muscle spasm and scoliosis, and to local back pain, commonly known as "lumbago" or "sacro-iliac trouble." Pain is aggravated by coughing, sneezing and straining, and possesses all clinical features of herniation of the intervertebral disk, though it does not radiate to the lower extremities.

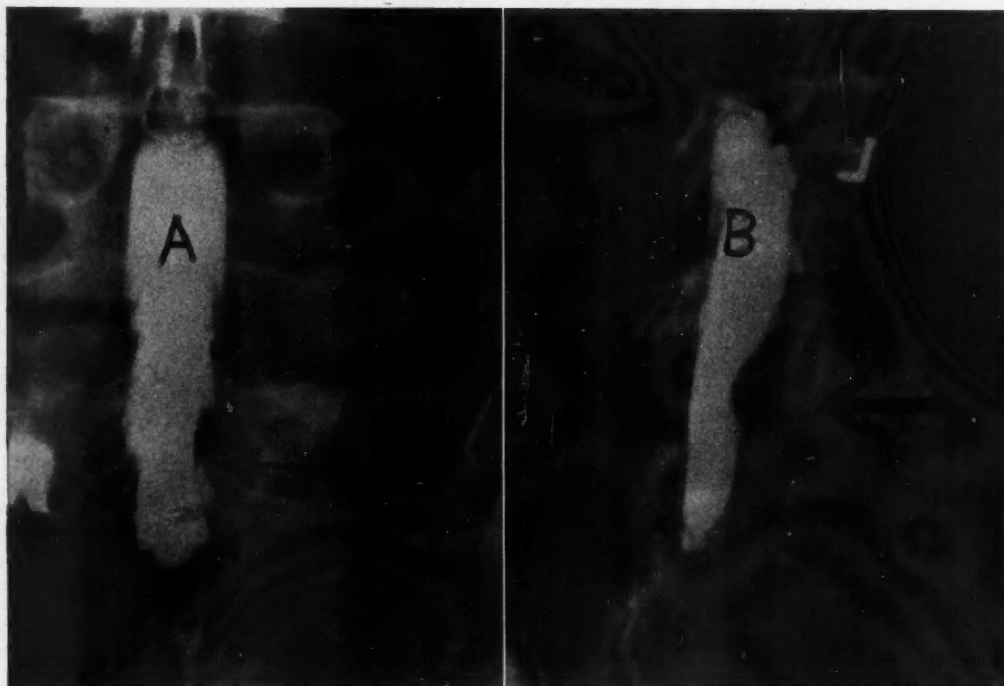


Fig. 3.—Filling defect demonstrating herniation of the nucleus pulposus: (a) arrow points to defect of axial nerve sheath pouch, produced by herniation of the nucleus pulposus from the fifth lumbar interspace; anterior-posterior view. (b) arrow points to defect in an oblique view.

## INFLAMMATION AND PRESSURE FROM NEOPLASM

Infectious diseases of the spinal roots are less frequently encountered than commonly assumed. They are preceded and accompanied by low-grade febrile reaction, for which no adequate explanation can be found. Such infectious diseases implicate a number of spinal roots and nerve trunks, resulting in wide distribution of pain and bilateral involvement. The reflexes are affected to a considerable extent. Paresthesia is common and muscle tenderness almost always present. When diseases, like pelvic malignancy or pelvic infection, lead to the sciatic syndrome, it is not too difficult to arrive at a diagnosis, even though the patient may have suffered trauma prior to the onset of these symptoms.

Low-grade infection of the prostate, characterized by slight increase of cells in its secretions, is commonly held responsible for the syndrome of ruptured intervertebral disk, combined with spinal root compression. Yet, such a relation is coincidental, and infection of the prostate does not cause the syndrome of single spinal root lesion.

## SUMMARY

The phenomena covered by indiscriminate use of the term "sciatica" should be carefully analyzed.

Herniation of the nucleus pulposus is one of the most common origins of recurring unilateral pain radiating into the lower extremities.

It derives frequently from recurring minor stresses to the back, especially when the structures involved are pre-disposed from congenital weakness, faulty posture, etc.

Characteristic clinical features of the ruptured intervertebral disk with herniation of the nucleus pulposus are analyzed.

Trauma to the annulus fibrosus, preceding spinal root compression through herniation of the nucleus pulposus, is described.

Low-grade infectious diseases, spinal neoplasms, etc., also cause pain, radiating into one or both extremities, but the clinical picture differs from that of herniation of the nucleus pulposus.

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## NEW CONCEPTS IN THE THERAPY OF INDUSTRIAL CONTACT DERMATITIS\*

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PHYSICIANS in industry, as well as physicians in general, have long been baffled or misled by such terms as allergy, sensitivity, and hypersensitivity. These terms have been widely used in the discussion of contact dermatitis, and in such a manner as to imply that they automatically explained the underlying process.

In two previous communications,<sup>1,2</sup> I have stressed the fact that most causes of industrial contact dermatitis are definite poisons. As such, these poisons can be neutralized by various antidotes.

The first step in dealing with a contact dermatitis is to determine the toxic irritant. This can be done by careful inquiry as to the industrial process in which exposure has occurred. Such a procedure should be followed by carefully-performed patch tests, in which care is taken to avoid the effects of primary irritation. The offending agent should then be tested as to its alkalinity or acidity, and for most substances litmus paper will give a satisfactory answer.

\* One of several papers in a Symposium on "Industrial Medicine in Wartime—the Widening Field of Industrial Medicine." Papers collected by Rutherford T. Johnstone, M. D.

## CHEMICAL NEUTRALIZATION

Direct chemical neutralization may be used. Thus a corrosive and irritant alkali can be neutralized by the use of a weak acid, such as acetic acid (vinegar) or citric acid (lemon juice), or even boric acid compresses. The following preparation was recommended by Reuter as a protection against alkaline solutions:

Rx—Lanolin .....	9.0
Stearic acid .....	50.0
Triethanolamine .....	2.70
Carbitol .....	18.0
Saturated solution of boric acid .....	120.0

Conversely the use of weak alkalies (sodium bicarbonate, sodium borate) is indicated in the neutralization of irritant acids.

## DETOXIFICATION

A second valuable procedure is the use of detoxifying chemicals. These act on the irritating chemical to form either insoluble or nonirritating chemical compounds. Thus the dichromates can be detoxified by sodium or potassium bisulphite. Five per cent sodium hyposulphite is useful in neutralizing chromic acid. Paraphenylenediamine can be made less toxic by wet compresses of 10 to 15 per cent sodium thiosulphate. Dermatitis from tincture of iodine can be neutralized by wet dressings of 5 to 10 per cent sodium thiosulphate. Dermatitis due to fluorides should be helped by repeated applications of a paste made of glycerine or liquid paraffin and magnesium oxide, followed by wet dressings of 10 per cent calcium gluconate. Dermatitis due to formaldehyde should be helped by wet compresses of either (a) a solution containing 5 per cent urea and 1 per cent ammonium phosphate, or (b) a solution of 10 to 15 per cent of sodium or potassium sulphite, or sodium and potassium bisulphite, used either alone or incorporated into liquid soaps (potassium salts only).

Weak solution of copper sulphate (1 per cent) is of value in neutralizing various types of irritation from phosphorus compounds. Wet compresses of magnesium sulphate (10 to 15 per cent) should be of value in cases of contact irritation from barium salts. In contact dermatitis due to picric acid and the picrates (butesin picrate) a paste of magnesium carbonate, or alcohol, or a 3 per cent solution of lithium carbonate, or liquid soaps containing 5 to 10 per cent potassium sulphite, should be tried. Sodium thiosulphate (10 to 15 per cent), or weak acids should be tried in cyanide dermatitis.

Sodium bicarbonate alone, or in combination, is said to be effective in dermatitis from zinc chloride. Sulphonated oils are worth a trial in the prevention of cement dermatitis. Injuries to the skin from nitric acid may be alleviated by lavage with water, scrubbing the stained areas with methyl alcohol and liberal amounts of sodium bicarbonate. Finally, the yellow stain should be removed by a weak Dakin's solution. Weak alkalies should be of value in cases of dermatitis due to rubber, as from respirators, etc.

## ADSORPTION

This third point of approach has been neglected in the treatment of external poisoning. Adsorption may be defined as a phenomenon of adhesion in an extremely thin layer of the molecules of gases, of dissolved substances, or of liquids, to the surfaces of solid bodies with which they come in contact. Such adsorbents are charcoal and kaolin. The former in various forms, e.g., wood, animal, and activated charcoals, has been widely used by chemical engineers, especially in removing noxious substances from drinking water. It is estimated that one cubic inch of charcoal possesses 20,000 square yards of adsorbing

surface; this property accounts for the use of similar substances in gas masks. Mercurial preparations and chlorinated hydrocarbons belong to a group of preparations which may be adsorbed by the following general antidote of McNally's, used externally:

Magnesium oxide	2 parts
Activated charcoal	} — 1 part
Tannic acid	
Purified Fuller's earth	

#### CLEANSING AND PROTECTIVE AGENTS

The unusual emulsifying and detergent properties of the newer synthetic wetting agents may be used to remove toxic chemicals from the skin, both in preventive therapy and perhaps in the therapy of the actual dermatitis itself. The trade names of some of these wetting agents are: Duponol, Gardinol, Alkanol, Mergol, Avicol, Nekal, Naccanol, Aerosol, Decerosol, Santomerse, Igepon, Triton, Orthopol, and Tergitol. Due to their penetrating powers, they can also be used to carry neutralizing or detoxifying agents. Such preparations have already proved of great value in the prevention of systemic poisoning and contact dermatitis from T.N.T. and tetryl.

#### CONCLUSION

The chemical aspect of contact dermatitis in industry is worthy of study and investigation. There are no "shot-gun" cures, and each problem demands considerable investigation before therapy is instituted.

2007 Wilshire Boulevard.

#### REFERENCES

1. Anderson, N. P. Contact Dermatitis, with Special Reference to Industrial Dermatitis—Preliminary Report, *Indust. Med.*, 12:584 (Sept.), 1943.
2. Anderson, N. P. Neutralization as a Therapeutic Principle in Contact Dermatitis—*Archives of Dermat. and Syph.*, 49, 176 (March), 1944.

## EMERGENCY TREATMENT OF HEAD INJURIES\*

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**I**N the treatment of head injuries there are established principles which, if followed carefully, will save many lives. The most important of these is close personal observation.

The extent of the initial brain injury should be determined at once, so that the physician may recognize and interpret any signs of increasing brain involvement, whether due to edema, hemorrhage, infection or softening.

Observe and record every thirty minutes the state of consciousness, pulse, respirations, blood pressure, temperature, size of pupils and response to light, muscle power of the arms and legs, and any reflex changes.

#### SIGNS OF INCREASING INTRACRANIAL PRESSURE

It is important to recognize signs of increasing intracranial pressure, particularly the early signs, and to combat them quickly. The state of consciousness is most important. Also, while compensation is present, the pulse and respirations will remain low and regular. The first signs of increasing intracranial pressure in a conscious patient is beginning stupor or sometimes restlessness. The pulse rate may drop to 50 per minute or lower, and the pulse pressure may increase. Restlessness may be a warning that coma is near, but it is sometimes due to a

full bladder. Later, when compensation begins to break, the pulse rate increases, and becomes variable in rate and volume, the pulse pressure increases, the respirations become rapid, shallow and irregular, and the temperature rises.<sup>1</sup> With increasing intracranial pressure, the stupor deepens, delirium, convulsions, twitchings and spasticity appear, and Cheyne-Stokes respirations may develop.<sup>2</sup>

The treatment of shock is of primary importance and supersedes all other considerations. Place the patient in a warm bed between blankets in a semiprone position with head lowered, and apply heat. Clean out the air passages by suction or dependent drainage. Give 50 c.c. of 50 per cent sucrose intravenously, and follow with 500 c.c. or 5 per cent glucose. In severe shock give blood plasma or whole-blood transfusion.

#### TREATMENT OF INCREASING INTRACRANIAL PRESSURE

1. *Do a spinal tap*, measure the pressure, and remove at least 25 cc.'s. Make serological tests. Repeat spinal taps every 8 to 12 hours and remove at least 25 cc.'s of fluid if the pressure continues or increases. Repeated spinal taps to reduce intracranial pressure in the presence of an expanding extradural or subdural hemorrhage are not a substitute for an operation, but are actually harmful in postponing surgery.

#### 2. Dehydration:

a. Limit fluid intake to an amount just sufficient for body metabolism—roughly 1,500 cc.'s.

b. Give hypertonic solutions intravenously—100 c.c.'s of 50 per cent sucrose. Excessive use of hypertonic solutions is harmful.

c. Obtain frequent liquid bowel movements by using four ounces of 50 per cent Magnesium Sulphate by rectum or Levine tube.

3. *Operation.* Consider this, if the patient is not responding to the above treatments. Subtemporal decompression is usually inadequate, but occasionally an unsuspected subdural hemorrhage or an hygroma is uncovered. It is much better to combine subtemporal decompression with a large flap, or use a bifrontal flap decompression.

Sedatives. Use phenobarbital or paraldehyde for sedation, but never morphine. Oversedation is dangerous.

Stimulants are sometimes necessary. Caffeine, coramine and metrazol are effective.

Nourishment should be maintained. Begin stomach feedings on the second day, if the patient is unconscious or won't eat. A daily fluid balance of 1,500 cc.'s to 2,000 cc.'s should be maintained.

X-rays should be taken only after the emergency stage, as they are seldom helpful. The fracture is important only if the brain is threatened, and we can ascertain this by inspection and palpation. The legal profession and the public still consider the fracture of the skull as the most serious injury, whereas the medical profession is concerned almost entirely with the injury to the brain.

#### REPAIR OF DAMAGE

If there is an open scalp wound, apply a tight, sterile bandage until shock is overcome. Then shave widely, wash with green soap and water, and apply antiseptic in an attempt to approach aseptic surgery. When the patient's condition warrants, debride the wound edges, remove dirt, discard dirty instruments, sift sulfanilamide powder into the wound and close without drainage. If a depression is beneath the laceration, the small pieces of bone are removed and the dura inspected for lacerations or the presence of a hemorrhage beneath. If a subdural hemorrhage is present, the dura is opened, the hemorrhage removed, bleeding vessels ligated, and the dura sutured with fine interrupted silk. If bony fragments or foreign bodies have been driven into the brain, these are removed, the macerated brain is removed by gentle irrigation and suction, sulfanilamide powder is sifted into

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the wound, and the dura is tightly sutured. Any dural defects may be closed by using a piece of adjacent periosteum. Slight depressions, unless compounded, may frequently be ignored.

Extradural and subdural hemorrhages should be operated upon as soon as the diagnosis is made. The usual signs are restlessness, advancing coma, dilatation of the pupil on the side of the hemorrhage, advancing paralysis of the face, arm and leg on the opposite side, together with signs of increasing intracranial pressure already mentioned. Frequently subdural hemorrhage does not materially affect the patient for days, weeks or months after the accident.

If there is a leakage of cerebral fluid from the ear or nose, these parts should never be sprayed or irrigated.

Major procedures for concurrent injuries, such as treatment of fractures, amputations, etc., should be delayed until recovery from the brain injury has taken place.

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#### REFERENCES

1. Dandy, Walter E., *Diagnosis and Treatment of Injuries of the Head*, J.A.M.A., 772-775 (Sept 2), 1933.
2. Mock, Harry E., and Mock, Harry E., Jr., J.A.M.A. 498-505 (Oct. 17), 1942.

## INDUSTRIAL UROLOGIC INJURIES\*

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**I**NDUSTRIAL injuries to the genito-urinary tract involve primarily the kidney, bladder, urethra, and scrotal contents. Only occasionally does an industrial injury concern the ureter, prostate, seminal vesicles, vas deferens, penis, or foreskin.

#### RENAL INJURY

The kidney may be injured by a direct blow, compression of the abdominal contents, or falls from a height, resulting in a direct contusion to the kidney or from fractured ribs piercing the kidney. Falls upon the feet, or upon the buttocks, have caused tears to the kidney or capsule.

Type I—A tear of the true capsule with resulting hematoma.

Type II—Mild contusions of the parenchyma, without gross signs of injury, occur with the symptom of pain and the finding of microscopic red-blood cells.

Type III—Superficial tears of the parenchyma are not uncommon. They usually are transverse and irregular, and do not extend deeply into the kidney.

Type IV—Deep tears, pulpefaction, or severing of the renal artery or vein; these are the most serious of renal injuries.

Ninety per cent of all kidney injuries fall under Type III.

Renal tears may result in scars, cicatricial tissue, hydrocalyx, hydronephrosis, chronic renal infection, or extravasation of blood and urine in the perirenal tissues.

#### DIAGNOSIS

It is of the utmost importance to diagnose a renal injury early and determine its degree. The outstanding symptom is hematuria; this occurs in 90 per cent of cases, and it is usually early. The degree of the bleeding when present indicates the severity of injury; for ex-

ample, a light staining, or merely microscopic blood cells, indicate a slight tear, provided the ureter is not plugged with a blood clot. Massive hematuria, a falling blood pressure, and shock point to a severe injury. Pain is usually present. It is often a typical renal colic with localized tenderness. As the hemorrhage progresses, a palpable tumor may form in the renal fossa. Accompanying this tumefaction is muscle spasm or rigidity.

Early in the picture there may be symptoms of shock. There may be no local evidence of hemorrhage and nothing to indicate it except hematuria. Patients who show signs of shock and/or hemorrhage bear the most critical watching. Half-hourly blood pressure readings are important in detecting a continuing hemorrhage. Fortunately clotting, intrarenal tension, and lowered blood pressure come to the patient's rescue. Many of the torn renal vessels are thus plugged with clots.

Excretory urograph is frequently, but not always, of value in determining the degree of injury. The affected organ may reveal an extravasation or show poor function. Due to shock, poor excretion of urine is the rule. Retrograde pyelograms are not usually recommended. Ureteral catheters and contrast media can readily displace a clot and further contribute to hemorrhage. Cystoscopy alone can easily add to the patient's shock. These examinations should be reserved until the patient is out of danger.

In summary, the diagnosis of renal injury is characterized by hematuria, unilateral renal pain, localized tenderness, muscle rigidity, and tumefaction.

#### TREATMENT

Treatment is readily divided into expectant and operative.

*Conservative or Nonoperative Treatment.*—As pointed out earlier, most kidney injuries fall into Types I, II, and III—tears of the capsule, contusions, and superficial tears. A mild hemorrhage takes place, clotting closes the open vessels, and absorption of the extravasated blood restores the kidney to its original form and condition. Therefore, in order not to disturb clotting, it is important to keep the patient perfectly quiet, and not to allow him to roll, twist, or bend the body. Warmth and blood plasma are often necessary for shock, and when there is hemorrhage blood, transfusion may also be needed. Often the pulse rate and blood pressure become well stabilized, and the patient goes on to a complete recovery. Again, it is best not to allow too much body movement until it is reasonably certain that all bleeding has been permanently checked. Ten days to two weeks of bed rest should be required after the last disappearance of the hematuria.

*Operative Treatment.*—Surgery is indicated when the hemorrhage persists or threatens the patient's life. Increased pulse rate, falling blood pressure, and severe pain are indications for exploration. The development of fever, chills, and tumor formation in the costovertebral angle, along with continued hematuria, may call for surgical intervention several days after the injury. It must also be realized that a tear of the renal artery or vein can quickly result in death. Most renal bleeding is arrested by normal clotting.

Suturing of severe kidney lacerations is not satisfactory, even with ribbon gut. Nephrectomy is much surer and safer, should the kidney be hopelessly torn. We have all seen cases where shock prevented immediate surgery or exploration, and the patient, after weeks of hospitalization, went on to recovery and restoration of function of the damaged organ. When surgery is necessary, it is good policy to wait until shock is over. Statistics show that operative treatment has a much higher mortality than conservative expectant treatment. On the

\* One of several papers in a Symposium on "Industrial Medicine in Wartime—the Widening Field of Industrial Medicine." Papers collected by Rutherford T. Johnstone, M. D.

other hand, Lowsley states, "I believe it is conservative to operate early." After all, judgment and experience must be applied to each of these injuries of the urinary tract. There can be no hard and fast rules.

#### RUPTURE OF THE BLADDER

The two most common causes of this accident are direct blows to the abdomen with the bladder full, and crushing accidents to the pelvis, as in falls, the pelvis being caught between cars or heavy objects, etc. The latter can cause a springing apart of the pubic bones due to fractures through the sacrum, or a splintering of the rami and puncturing of the bladder with sharp bone splinters. These ruptures may be extra- or intraperitoneal; the latter, of course, being more serious. The symptoms usually develop early. Bleeding from the penis, voiding bloody urine, suprapubic pain, rigidity of the lower abdominal muscles, and shock are of frequent occurrence.

**Diagnosis.**—Early diagnosis is possible by air or contrast media cystograms, excretory urograms, or cystoscopy. The cystograms of air are preferable. As the hours pass, pain and suprapubic tenderness increase. The abdominal muscles become splinted and board-like. The pulse rate goes up. Ecchymosis over the pubic bones, the scrotum, or perineum point to a severe injury. On the other hand, a case of intraperitoneal rupture of the bladder was seen a few years ago in which the abdomen was perfectly soft for three days. The patient voided clear urine, and yet died of peritonitis from a small rent in the dome of the bladder.

If the patient cannot void, and if a catheter cannot be passed to the bladder, it is evidence that the membranous urethra has been severed. The patient should attempt to void, and, if he cannot, catheterized specimen of urine should be examined for red blood cells. If there is any question of diagnosis, the condition should be treated as a potential rupture.

An indwelling urethral catheter may clear up the picture. At times, a contusion of the urethra, with mild bleeding, will be cleared up by such a catheter. A cystogram can be made at the same time.

**Treatment.**—Treatment of a ruptured bladder is most obviously one of early surgery. Hinman states: "Ruptured bladder is one of the few emergency urologic operations. It should be operated on within a few hours." All surgeons urge early cystotomy, for the mortality is high—25 to 45 per cent—and rapidly increases as the post-traumatic hours progress. Even with all our roentgenographic aids, it is not always possible to diagnose rupture of the bladder; so, when in doubt, operate if the patient is not in shock.

#### RUPTURE OF THE URETHRA

Rupture of the urethra occurs chiefly in crushing of the pubic arch and blows delivered to the perineum, as in straddle falls. The symptoms are bleeding from the meatus, inability to urinate, and inability to pass a catheter. There is usually the distress of an over-distended bladder, tenderness of the site of injury, and ecchymosis. As time elapses, edema takes place, and invasion of the scrotum or perineum with blood and urine occurs. Infection follows.

**Treatment.**—The only treatment is operative. There is the choice of suprapubic cystotomy, drawing a catheter through the severed urethra, or external urethrotomy. In the latter treatment, an attempt can be made to suture the severed urethral ends.

There are other industrial urologic injuries, such as those of the penis, scrotal contents, prostate, and vesicles.

The more usual injuries, however, are the ones considered above.

It is emphasized that conservative treatment gives the best results with kidney injuries, and very early surgery is important in bladder or urethral ruptures.

1215 Fourth Avenue

### THE TREATMENT OF SOFT-TISSUE INJURIES TO THE HAND\*

**I**N INDUSTRY, the incidence of soft tissue injuries to the hand is alarmingly high. Since these injuries are extremely susceptible to infection, often leading to such complications as permanently-impaired function of the part, amputation, or even loss of life, their treatment is a major procedure. Especially is it imperative that the patient, with a severed nerve or tendon, be hurried to a hospital where the best surgical facilities are available. The repair of this type of laceration should be done within the first six hours following injury, for delay invites infection, and consequently prevents or retards healing.

In wounds where the time interval following injury has been longer than six hours, the decision as to operative procedure is influenced by certain factors. If the wound is greatly devitalized and obviously dirty, a simple dressing is applied without attempt at repair; or, if the delay has been longer than twenty-four hours, primary suturing of the nerves or tendons should not be done. On the other hand, primary suturing of the nerves or tendons can often be done after twelve hours, or even up to twenty-four hours if, at the time of injury, the first-aid treatment consisted of the implantation of sulfanilamide, and the application of sterile dressings, and if the wound appeared clean.

#### OPERATIVE PROCEDURE

Preparation of the extremity to be operated upon consists of shaving the area around the wound, and cleansing with soap and water. The entire extremity is then painted with equal parts of tincture of iodine and alcohol, save the wound itself, which has been covered with sterile gauze. The arm is elevated, sterile towels are wrapped about it, and an Esmarch bandage is applied. This bandage is wrapped about the extremity to a point one and one-half inches distal to the blood pressure cuff, which has been previously applied to the upper arm. The cuff is then inflated to 300 mm. of mercury pressure and both tubes clamped. (This type of tourniquet may be left on as long as one and one-half hours without injury to the nerves). The Esmarch bandage is then removed. Local, or block anesthesia, of 2 per cent novocain (or in prolonged cases, a general anesthesia) is administered. Adrenalin is never used in digital block anesthesia, because prolonged ischemia may result in necrosis. The wound is then sterilized with equal parts of iodine and alcohol, but the wound *should not* be washed out with saline, sterile water, or other solutions, as is frequently practiced. It is Boehler's opinion that solutions wash foreign particles deeper into the wound and only leave a false impression as to what constitutes surgical asepsis. It is now generally accepted that the technique of wound excision, as described by Boehler,<sup>1</sup> has reduced the incidence of infection in this type of injury.

\* The author, being in military service, desires to remain anonymous.

One of several papers in a Symposium on "Industrial Medicine in Wartime—the Widening Field of Industrial Medicine." Papers collected by Rutherford T. Johnstone, M. D.

Complete excision of the wound is accomplished by beginning at one edge, removing approximately  $\frac{1}{4}$  of an inch in thickness across its base, including  $\frac{1}{4}$  of an inch of the skin border on the opposite side, but sparing tendons, blood vessels, and nerves. The ends of the injured nerves and tendons are cut off sharply, and soiled portions of bone are removed by means of a chisel or gouge. By this procedure, all the iodine is completely and systematically removed, as well as all particles of dirt and devitalized tissue. The potentially-infected wound thus becomes more nearly aseptic, and more nearly free of irritating chemicals. All remaining structure are potentially viable. After such an excision of the wound is accomplished, the instruments used are discarded and fresh drapes are applied. A new set of sterilized instruments is then brought into use.

Before removing the tourniquet, all structures that need repair, such as tendons and nerves, should be identified. After its removal the wound is covered with sterile gauze and manually compressed; bleeders are identified and tied off with triple "O" catgut, following which the operator is free to complete the suturing of all severed structures. Before describing this technique, it should be stated that nerves, bones, and joints should be covered, since these structures do not remain viable if left exposed. Skin flaps from adjacent areas may be utilized. Defects resulting from the transposition of these flaps may then be filled in with Thiersch skin grafts.

#### TENDON SUTURES

The ends of severed extensor tendons can, in most instances, best be approximated by means of No. 35 stainless steel wire, as advocated by Bunnell.<sup>2</sup> The double figure-of-eight suture is used, and the skin borders overlying the tendon are approximated by the continuation of this suture in the form of a mattress stitch through the skin. The skin borders of the remaining portion of the surgical incision are then approximated by intermittent mattress sutures of silk supported by a continuous running suture of No. 35 stainless steel wire. The use of stainless steel wire has been noted consistently to provide very little or no reaction, as compared to other materials. Sulfanilamide may be implanted in the wound before closure. Either tetanus toxoid or tetanus antitoxin is administered in all such injuries.

The flexor tendons, when severed, yield the poorest result, since they are enclosed in a tunnel-like sheath. Because of the firmness of this tunnel, the swelling following surgery impairs the blood supply and the structures may subsequently become ischemic or necrotic. The tendon may also become fixed by a firm scar, resulting in a stiff finger and loss of function. For this reason the sheath should be divided on its lateral surface. It is also preferable to use a suture material which produces the least reaction, as well as to approximate the severed tendon ends with as simple a stitch as possible.

Where flexor tendons of the fingers and hand are severed at the same level, it may be advisable to remove the flexor sublimus tendon, and suture only the flexor profundus. The latter can be accomplished by means of placing a wire suture through the proximal and distal portions of the tendon. This suture, in turn, is brought out through the tendon sheath and the skin at a point distal to the site of severance, and fixed by tying the knot over a small piece of rubber tubing, or to the nail of the involved digit. The pull-out wire passed through the proximal loop of the suture is brought out through the tendon sheath and skin. Like-

wise, this suture is fixed by tying it over a small piece of gauze, or rubber tubing, proximal to the site of repair. These sutures remain in place for a period of three to four weeks. If a pull-out wire is used, the entire suture can be removed from the tendon, after healing takes place. Should infection interrupt healing, the suture can be removed at any time. If stainless steel wire is not available, standard methods of suture can be carried out utilizing Deknata No. 2 silk. If only the sublimus tendon is severed, it need not be sutured, since it is not essential for good function and only serves to balance the flexor mechanism of the finger.

#### NERVE REPAIR

Nerves are sutured with fine silk, using a small, straight needle. The severed ends are approximated by means of interrupted fine sutures taken at regular intervals about the circumference of the nerve sheath. Passing sutures through the nerve substance is avoided, and the approximated ends should never be under tension.

After completing the treatment of the wound in all its manifestations, it is advisable to elevate the injured extremity by means of an aeroplane splint until acute swelling has subsided. This relieves compression of tissue, especially nerves and blood vessels, by gravity edema. It also decreases pain and hastens recovery.

#### REFERENCES

1. Boehler, L., *The Treatment of Fractures*, John Wright and Sons (Bristol), 4th Ed., 1935.
2. Bunnell, S., *Treatment of Tendons in Compound Injuries of the Hand*, J. Bone and J. Surg., 23:240, 1941.

## HAND FRACTURES IN INDUSTRY\*

C. C. CUTTING, M.D.  
Oakland

THE HAND, a tremendously important organ to any workman, is subject to a high incidence of injury, and deserves a great proportion of industrial medical attention. Because of the extreme importance that all possible function be restored after an injury to the hand, even small and apparently insignificant injuries must be respected, and receive careful and intelligent care. Lacerations and contused wounds, even though apparently minimal in extent, may communicate with tendon sheaths, joint spaces, or closed compartments which have poor tissue resistance to infection, but infections of which may lead to severe disability. Early definitive care is imperative, and should include immaculate cleansing with soap and water, thorough debridement, local sulfonamide application, closure without drainage, and adequate immobilization.

Fractures of the skeletal structures of the hand present a particularly serious problem, since they may lead not only to deformity of the bony structure, but their close proximity to tendons and joints may markedly limit the function of these structures as well.

#### FRACTURES OF THE TERMINAL PHALANGES

Fractures of the terminal phalanges occur more frequently than fractures of any other bones of the body. Fortunately, there is little tendency toward separation of the fragments, and disability from this injury is rare. Immobilization for two weeks by a protective metal finger splint will usually be sufficient. Compounded fractures of the terminal phalanges may shatter the bone and the removal of separated fragments should be in-

\* One of several papers in a Symposium on "Industrial Medicine in Wartime—the Widening Field of Industrial Medicine." Papers collected by Rutherford T. Johnstone, M. D.

cluded in the debridement. Removal of sufficient bone to allow a well-padded, soft-tissue flap on the end of the bone is far superior to attempts at skin grafting. It is frequently advisable to remove the proximal third of the nail in compound injuries involving this region. This procedure allows free drainage of infection about the eponychium, decompresses painful subungual hematomata, and may result in a smoother second-nail growth.

A special problem of the terminal phalanges is the so-called baseball fracture, or avulsion, of the extensor tendon with displacement of a chip from the articular surface of the terminal phalanx. Usually the extensor tendon does not retract and immediate fixation in plaster, maintaining the distal joint in hyperextension and the proximal interphalangeal joint in flexion for six weeks, is the treatment of choice. The results of those injuries which include a chip fracture are, as a rule, much better than those consisting of tendon avulsion only. The results from open reduction are less favorable than those with closed treatment, instituted early.

#### FRACTURES OF THE MIDDLE AND PROXIMAL PHALANGES

The displacement of the fragments following fractures in these regions may require immobilization with the finger in either flexion or extension, as dictated by x-ray appearance. In general, fractures distal to the middle of the shafts of those bones will require fixation in flexion.

Skeletal traction is usually indicated in comminuted or compounded fractures of these bones, and should be applied in line with the desired position of the finger.

Compounded fractures of these regions present the poorest end results of this entire group of fractures, because of tendon adhesions and joint fixations. Immobilization time should be minimum, and active motion can usually be instituted within two to four weeks.

#### FRACTURES OF THE METACARPALS

The first metacarpal is frequently fractured near its base and may be of two general types. The transverse, impacted type, not involving the carpal-metacarpal joint, does not require traction, and simple correction of the adduction deformity by disimpaction and abduction is sufficient. Those fractures of the base of the first metacarpal, extending obliquely into the joint, are unstable, usually shortened and require skeletal traction for about four weeks.

Fractures of the metacarpal shafts usually result in dorsal angulation, because of the stronger pull of the flexor muscles, and should be maintained in well-moulded plaster, incorporating at least the neighboring fingers. The fingers themselves may be in partial flexion, but should be supported by the cast, which fits firmly beneath the metacarpal heads. These fractures are prone to be oblique and to shorten, and again skeletal traction should be applied and maintained to overcome all over-riding.

Fractures at the neck of the metacarpal often present a difficult problem. Impaction should be broken up and padded pressure applied within the cast. Acute flexion of the finger, and upward pressure in line with the proximal phalanx, may obtain a reduction otherwise impossible to achieve. The metacarpo-phalangeal joint is especially vulnerable to puncture wounds, which require immediate and adequate debridement.

#### IN CONCLUSION

In general, emphasis should be placed upon the following:

- (1) Early definitive care of fractures of the hand to a point that they are considered a surgical emergency.
- (2) Accurate reduction, and traction when necessary.

- (3) The use of nonpadded, well-moulded plaster casts which obtain maximum immobilization of the fragments, and yet allow maximum function and use of the non-injured portions of the extremity. Use of the uninvolved portions of the hand during immobilization should be encouraged, for it will greatly speed recovery and lessen disability resulting from fractures of the hand.

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## TREATMENT OF INDUSTRIAL EYE INJURIES\*

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THE prerequisites to good industrial ophthalmology are good light, good vision, and good instruments. Each emergency unit should have a separate cubicle for eye-cases. In this space there should be good light, a binocular loupe, a few drugs, including an anaesthetic, such as pontocaine or butyn, also mercurochrome (one per cent) and a solution of boric acid; a sharp-pointed and a dull spud, and alcohol (seventy per cent) for sterilizing instruments. I feel that argyrol should not be on this list, as it is too often confused with tincture of iodine. Yellow oxide of mercury is irritating. The use of mydriatics, except in extreme cases, should be left to the judgment of the ophthalmologist.

Foreign bodies of the cornea should be treated with great respect. Those in the center should be referred to an ophthalmologist, as bad results are costly in man-hours, and large permanent disability ratings. Those at the limbus do not justify such great care. Give the anaesthetic time to work, and the patient will be more coöperative. If the foreign body is superficial, attempt to remove it with a tightly-wrapped, moist cotton applicator. If unsuccessful, use your spud, follow with a drop of mercurochrome, which not only stains and may show other wounds or foreign bodies, but also acts as a germicide. Inspect the everted lid of the injured eye, and also examine the opposite eye. Apply a pad for an hour or two, as, according to Behrens, the lachrymal secretion is an effective germicide. Instruct the patient to return the same day, if irritation continues, and also to return the next day for observation and a rating of vision if the eye is in good condition.

Every red eye seen is not necessarily an injured eye or a conjunctivitis. Conjunctivitis usually shows redness, swelling, and discharge. Iritis and glaucoma also cause redness in the eye, but no discharge. These two conditions are too often treated as a simple conjunctivitis, until visual damage has been done. Severe pain indicates a deeper inflammation; wherefore, if not sure of your diagnosis, refer the case to an ophthalmologist. A conjunctivitis usually responds rapidly to treatment.

Kerato-conjunctivitis is difficult to diagnose in the early stages. The patient usually has a tearing, red eye, with the sensation of a foreign body or an arc burn. Eventually, follicles appear in the lower cul-de-sac. There may be a slight rise in temperature; later on, swelling and tenderness of the preauricular glands on the affected side.

Flash burns always involve both eyes, and usually the symptoms do not appear for several hours after exposure, with photophobia, tearing and sensation of sand in the eyes. Treatment is a mild anesthetic, combined with adrenalin or other vasoconstrictor, cold compresses and protection from light. The discomfort lasts only a few hours.

\*One of several papers in a Symposium on "Industrial Medicine in Wartime—the Widening Field of Industrial Medicine." Papers collected by Rutherford T. Johnstone, M.D.

Chemical burns require copious flushing with water or boric acid. Always evert the upper lid, and remove any foreign particles and flush for twenty minutes.

These are the common cases which come to the emergency station. Any penetrating injury should immediately be referred to a specialist. Let me repeat: approach all injured eyes with clean hands, good light, and good vision.

523 West Sixth Street.

## TREATMENT OF BURNS\*

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Santa Monica

THE fundamental principles in the management of burns are so well known that it is hardly necessary to repeat them:

1. Treatment of shock and relief of pain,
2. Prevention of infection and local treatment,
3. Attention to early functional return,
4. Correction of deformities or defects by skin graft, etc.

The treatment of shock involves relief from pain with copious doses of morphine. In a healthy adult male, as much as  $\frac{1}{2}$  gr. of morphine may be given at one time, and repeated whenever necessary.

### REPLACEMENT OF LOST PLASMA

Plasma should be given in adequate amounts until the plasma balance has been reached. In a severe burn case, the author has given as much as 3000 cc. within eight hours. The most reliable method of calculating the amount of plasma required is that of Harkins:—100 cc. of plasma for every point above 45 in the hematocrit reading.

In the initial treatment of shock, the use of adrenal cortical extract has been reported favorably by some investigators and discounted by others. The action of the cortical extract is to restore the capillary walls to their normal state of permeability, and thus prevent protein loss. If epinephrine is used to any extent in cases of severe burns, frequent blood determinations of epinephrine should be made. In this connection, all cases of severe burns should have frequent plasma chloride determination and hematocrit readings, until the danger stage is passed.

Replenishing fluid loss can usually be accomplished by intravenous normal saline. It should be given in quantities sufficient to produce at least 1,000 cc. of urine daily. Fruit juices, to which glucose has been added, are important in combating hepatic damage.

It is imperative that the burned areas receive a meticulous and carefully-planned debridement and cleansing over the entire area. It is only thus that infections are prevented and convalescence is shortened. After the patient has been anesthetized with a general anesthetic or large doses of morphine, or a general anesthetic that is advisable in the circumstances, the cleansing is begun. Copious amounts of green soap are used in the first stage of the cleaning process. This is followed by irrigations (using sometimes gallons of sterile normal saline) to irrigate the burned fields.

### DEBRIDEMENT

The debridement is the next important stage. This procedure is entitled to the same aseptic precautions as

a surgical operation. The surgeon should scrub his hands and wear a mask, cap, gown and sterile gloves. All dead and unhealthy looking tissues are excised. Blebs should be left intact for two reasons: In the first place, they conserve the plasma which is in the bleb, and will be reabsorbed into the general circulation; and, in the second place, one less avenue of infection is kept closed.

To prove any one method to be superior to all others, stringent scientific checks and rechecks should be made with control series of large numbers of cases where burn cases can be classified in regard to (a) extent of burn, (b) depth of burn, (c) preliminary soiling, (d) length of time between burn and inauguration of treatment, (e) age, (f) structures involved.

On one occasion a patient presented himself with what appeared to be identically extensive burns on both hands, fingers and arms. For comparison, the left arm was sprayed with Pickrell's solution and a triple dye-method was used on the right arm. Daily salt water immersions, with active movement of the fingers, were begun on both hands after the fourth day. It was very noticeable that the hand, which was being sprayed with Pickrell's solution, responded far better. There was less pain on active motion, and the end result was superior to the hand which had received the triple dye treatment. In addition, two infected areas developed after the use of the triple dye with the formation of pus.

### LOCAL APPLICATIONS

Since 1925, when tannic acid became the popular treatment for burns, literally dozens of medicaments in the forms of solutions, ointments and chemicals have been enthusiastically recommended.

Every chemical, agent, ointment or spray has its champion. The author has used Pickrell's 3 per cent sulfadiazine spray on many occasions with very satisfactory results.

True, bactericidal action is exercised from the outset. The sulfadiazine spray contains a wetting agent. The author uses no dressings on burned areas. The burned areas are sprayed daily with Pickrell's solution, and although there is preliminary discomfort, the patient feels much relieved fifteen or twenty minutes after the spraying has been applied. Recently the use of pressure-dressing has become popular, with splinting in cases where the extremities have been badly burned. It is said that lymphatic circulation of the part is restricted, and there is marked decrease in exudation from the surface. Practically no infections have followed this procedure. This is a valuable adjunct to treatment when skin graft is contemplated, since the poor results of skin grafting are usually attributable to low-grade infections in the eschar and granulation areas. In this connection it is advisable that no skin grafting be accomplished until sterile cultures from the burned areas have been obtained.

The transparent jacket system recently advanced by Beverly Douglas has many advantages, especially when proper hospital facilities are available, and it appears to be a valuable addition in the treatment of burns. This jacket is a transparent, cylindrical tubing of cellulose acetate with one end closed by a flat, or rounded head of the same material. This type of jacket may be hermetically sealed at a point above the burned area. The atmosphere surrounding the wound may be regulated at will in these jackets. The hermetically-sealed closure and covering provide many useful purposes. The patient may turn in bed, thus preventing development of contractures, decubitus ulcers and outside sources of contamination. The jackets may be completely filled with normal saline or other solution, and a constant flow established by the drip method. The advantages of visibility is not minimal, since early evidence of pressure sores, decubitus ulcers, etc., can be detected.

\* One of several papers in a Symposium on "Industrial Medicine in Wartime—the Widening Field of Industrial Medicine." Papers collected by Rutherford T. Johnstone, M. D.

## CONCLUSIONS

1. The primary consideration of shock should never be overlooked. It is vitally important to adopt and learn a simple method for determining the amount of plasma, versus cells, and administer plasma accordingly. The Harkins method is recommended.

2. The preparation of the burned patient is an aseptic surgical procedure.

3. Pickrell's solution of sulfadiazine spray is the procedure of choice, with daily normal saline hydrotherapy as an adjunct.

Pressure bandages and transparent jacket system are discussed.

3000 Ocean Park Boulevard.

## CONTROL OF TOXIC EXPOSURES\*

(Concluded from Page 13)

per cent of the velocity within the duct. Therefore, it is essential that any exhaust system must be applied at the point of origin of the material over which control is desired; i.e., it must be truly local exhaust ventilation.

(Special Note: the above-mentioned are general control principles, and it must be stated that there are certain measures which may be employed in special instances, such as wetting to minimize a dust problem.)

When all of these methods of control must be ruled out because of some production snag or lack of materials, or because the expense is not justified, e.g., short-time exposure to relatively low concentrations, the last resort is . . .

5. *Personal Protective Equipment.* There are many types of personal protective equipment for protection against mechanical injury as well as occupational diseases. Inasmuch as occupational diseases most frequently arise from the inhalation of toxic agents, said personal protective equipment is usually in the form of some type of respirator. In general, respirators are uncomfortable to wear, and their sanitation is not always what it should be. Consequently, the workers will frequently not wear the respirators. Hence, control of the environmental air is much more effective than the uncertain use of individual respirators.

However, there are times when the only alternative is the use of respirators. Each type of respirator is designed for a specific hazard. Not infrequently, however, we have noticed that a simple dust respirator is employed for the desired purpose of controlling an organic vapor hazard. Table 1 is a ready-reference chart listing the basic exposures with appropriate respirators indicated, as well as the limitations thereof.

808 North Spring Street.

## Diphtheria in California

(COPY)

CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH  
BUREAU OF EPIDEMIOLOGY

## Diphtheria Cases Reported by Months for Year 1944

January	127
February	118
March	119
April	94
May	103
June	90
July	59
August	83
September	67
October	93
November (reports received through Dec. 5) . . .	148
Total	1101

\* Conclusion of article by Hugh Dierker, M.D. and Paul G. Brown.

(COPY)

California State Department of Public Health  
Notice to Health Officers

December 4, 1944.

Attached is a copy of a letter sent to all physicians in Berkeley and Oakland by their respective health officers, calling attention to the presence of the *Gravis* type of diphtheria.

This type of diphtheria calls for prompt administration of antitoxin in maximum dosage. Because speed is essential in treating this type of diphtheria it is recommended that physicians treat all suspected cases of diphtheria with antitoxin at once without waiting for laboratory confirmation.

Your attention is called to the fact that the *Gravis* type cultures may not develop characteristic morphology with 24 hour incubation, but that it may be necessary to incubate cultures for 48 hours or longer before the organisms may be identified.

In serious cases of diphtheria from which only negative cultures are obtained it is recommended that subcultures be sent to the State Laboratory for further study.

Bureau of Epidemiology, 1122 Phelan Bldg.,  
San Francisco, 2.

CITY OF OAKLAND  
Department of Public Health  
CITY OF BERKELEY  
Department of Public Health

Dear Doctor:

During the past three weeks we have had in the East Bay Area a sudden increase in diphtheria. To date we have had 13 cases and 3 deaths.

The fact that makes this especially important is that the B, diphtheria is of the *Gravis* type. This is the most toxic type, originally reported in England, and reported throughout the United States increasingly during the past ten years.

Myocardial damage is extremely common in this type of infection, death taking place from seven to ten days after the onset of the disease and following clearing of the throat infection.

Throat cultures from suspected cases cannot be considered negative unless no organisms are seen following 48 hours incubation.

Immediate treatment is recommended on all suspicious cases (sore throat with suggestive membrane and low temperatures) regardless of culture findings.

Diphtheria antitoxin given—10,000 units intra venously and 30,000 units intra muscularly as soon as a provisional diagnosis is made, is recommended.

Additional antitoxin may be advisable during the first 24 hours if the case shows any degree of toxicity.

Prolonged bed rest in all cases is advisable.

Booster doses of toxoid are recommended for all children whose primary immunization was 2 years or more ago.

Sincerely,

(Signed) S. F. FARNSWORTH,  
S. F. Farnsworth, M.D.,  
Health Officer, Oakland.

(Signed) FRANK L. KELLY,  
Frank L. Kelly, M.D.,  
Health Officer, Berkeley.

Basil Valentine, possibly the pseudonym of Johann Thölde, an alchemist of Franckenhausen, was the author of "The Triumphant Chariot of Antimony," printed in 1604, in which a mixture of mercury, lead and antimony is recommended in the treatment of syphilis.

# CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

## CALIFORNIA MEDICAL ASSOCIATION†

LOWELL S. GOIN, M. D. .... President  
 PHILIP K. GILMAN, M. D. .... President-Elect  
 E. VINCENT ASKEY, M. D. .... Speaker  
 PHILIP K. GILMAN, M. D. .... Council Chairman  
 JOHN W. CLINE, M. D. .... Chairman, Executive Committee  
 GEORGE H. KRESS, M.D. .... Secretary-Treasurer and Editor  
 JOHN HUNTON ..... Executive Secretary

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## OFFICIAL NOTICES

### SPECIAL MEETING: C.M.A. HOUSE OF DELEGATES Important Attention of C.M.A. Members Is Called to: Proposed Compulsory Health Insurance Law for California

*Note. In the current issue, on page 1, editorial comment is made concerning the sequence of events that led up to the Special Session of the House of Delegates of the California Medical Association and the proceedings that have followed.*

*The series of minutes, resolutions and press notices which follow, appear in this department, because the importance of the issues involved, make it desirable that proper record be kept in the OFFICIAL JOURNAL of the California Medical Association.*

*The resolutions adopted by the C.M.A. House of Delegates, representing the decisions of that authority, appear in the current number, on page 32.*

*(For index of items which follow, see page 40.)*

\* \* \*

### EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION

#### Minutes of the One Hundred Eighty-sixth (186th) Meeting of the Executive Committee of the California Medical Association

An informal meeting (minutes as here given were approved by mail vote) of members of the C.M.A. Executive Committee, and members of the C.M.A. Council and other Officers of the Association was held in San Francisco on Tuesday, December 12, 1944, at the hour of 7:00 P.M.

#### 1. Roll Call:

Executive Committee Members Present: John W. Cline, Chairman; Lowell S. Goin, Karl L. Schaupp, and George H. Kress, (ex-officio).

Absent: Philip K. Gilman (illness); E. Vincent Askey (transportation).

Council Members Present: Sidney J. Shipman, Edwin L. Bruck, Lloyd E. Kindall, John W. Green, Donald Cass, L. A. Alesen, R. Stanley Kneeshaw, Frank A. MacDonald, Sam J. McClendon.

Present by Invitation: Dwight H. Murray, Chairman, Committee on Public Policy and Legislation; J. B. Harris, Hartley F. Peart, Esq., Legal Counsel; Howard Hassard, Esq., Associate Legal Counsel; Mr. John Hunton, Executive Secretary; and Mr. Ben Read, Secretary, Public Health League of California.

Letters were received from the following Councilors who regretted their inability to be present: Philip K. Gilman, Council Chairman; H. A. Johnston, Edward B. Dewey, Dewey R. Powell, Earl R. Moody, A. E. Anderson, E. Vincent Askey, Harry E. Henderson.

#### 2. Prospective Compulsory Health Legislation:

The meeting was called to order by Executive Committee Chairman John W. Cline, who said he would call upon members to informally discuss problems of medical care of groups of low-income citizens of California. Dr. Cline stated that imminent legislation for compulsory

† For complete roster of officers, see advertising pages 2, 4, and 6.

sickness insurance had been called to the attention of Council Chairman Gilman.

A general discussion followed concerning the information to the effect that one or more of the major Labor organizations would submit to the California Legislature, when it convened on Monday, January 8, 1945, drafts of one or more bills containing provisions for a compulsory sickness insurance system, to be conducted under the supervision of the State of California.

The discussion was participated in by many of the C.M.A. Councilors who were present.

Mention was made that Council Chairman Gilman had called an informal meeting of members of the Council of the California Medical Association, to be held on Wednesday noon, December 13th, at which Governor Earl Warren of California had been invited to address the group.

In the further discussion, comment was made concerning possible details of compulsory sickness insurance plans.

The meeting being of an informal nature, no action was taken other than to agree that all present should make a special effort to be present at the meeting on the following day at which the Governor of California would be the Guest Speaker.

JOHN W. CLINE, M.D., *Chairman.*

GEORGE H. KRESS, M.D., *Secretary.*

(COPY)

State of California

Governor's Office

Sacramento 14, December 22, 1944

George H. Kress, M.D.,  
Secretary-Editor,  
California Medical Association,  
450 Sutter Street,  
San Francisco 8, California.

Dear Dr. Kress:

Governor Warren has received your letter of December 18th enclosing copy of letter written by Dr. Harris of Sacramento, and copy of the Official Call for a special session of your House of Delegates.

He has asked me to state to you that he appreciates the thoughtful manner in which your Association is approaching this problem, and will be interested to follow the result of your deliberations.

Sincerely,

(Signed) BEACH VASEY, *Legislative Secretary.*

#### COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

#### Minutes of the Three Hundred Twenty-First (321st) Meeting of the Council of the California Medical Association

An informal meeting (minutes as here given later approved by mail vote) of members of the Council of the California Medical Association, to which had been invited members of the Board of Trustees of California Physicians' Service, and others, was held in San Francisco, at the Family Club, on Wednesday, December 13, 1944, at the noon hour.

#### 1. Roll Call:

The meeting was attended by the following:

Councilors present: Philip K. Gilman, Council Chairman; John W. Cline, Vice-Chairman; Edwin L. Bruck, John W. Green, Donald Cass, Lloyd E. Kindall, R. S. Kneeshaw, Karl L. Schaupp, Lowell S. Goin, Sam J. McClendon, Sidney J. Shipman, and George H. Kress, Secretary.

Present by Invitation: The Honorable Earl Warren,

Governor of California; Ray Lyman Wilbur, T. Henshaw Kelly, H. R. Madeley, C. Glenn Curtis, Chester L. Cooley, members of Board of Trustees of California Physicians' Service; Dwight H. Murray, Chairman C.M.A. Committee on Public Policy and Legislation; Wilton L. Halverson, Director of Public Health, State of California; J. B. Harris of Sacramento; H. Gordon MacLean of Oakland, Hospital Service of California; Ernest Sloman, D.D.S., Dean College of Physicians and Surgeons (Dental), San Francisco; Hartley F. Peart, Esq., C.M.A. Legal Counsel; Howard Hassard, Esq., Associate C.M.A. Legal Counsel; John Huntton, C.M.A. Executive Secretary, Ben Read, Secretary, Public Health League of California; Messrs. Sweigart and Vasey, Secretaries to Governor Warren.

Councilors and C.P.S. Trustees who wrote it would be impossible to be present included: Councilors A. E. Anderson, H. A. Johnston, Dewey R. Powell, Edward B. Dewey, E. Earl Moody, Frank A. MacDonald, and H. E. Henderson; C.P.S. Trustees C. L. Mulfinger, Rt. Rev. Thomas J. O'Dwyer, Glenn Myers, and A. E. Moore.

#### 2. Purpose of Meeting:

Council Chairman Gilman opened the meeting by calling attention to trends of thought and action on the part of large groups of citizens not only in California, but throughout the United States, regarding plans to bring about a betterment in distribution and availability of adequate medical care, with special relation to the needs of citizens belonging to the lower income groups.

Council Chairman Gilman stated information had been received that at the next session of the California Legislature, which would convene on Monday, January 8, 1945, it was more than possible that one or more bills would be submitted by lay groups, providing for the institution of a compulsory sickness insurance system in California.

Because, in such proposed legislation, State and possibly Federal financial aid would be involved, it had been deemed desirable to invite the Governor of California to informally address the Officers of the California Medical Association on the above and related subjects.

#### 3. Informal Address by Governor Earl Warren:

Governor Earl Warren then addressed the assembly.

In his presentation, Governor Warren stated that he had been happy to accept the invitation of the Officers of the California Medical Association to speak to them on the important subject of medical care, because his own observations had led him to believe that there was a distinct feeling on the part of a large number of voting citizens that ways and means should be provided, whereby adequate medical care would be made available to California citizens belonging to the low income groups. He was happy to outline his observations and view in informal manner to those present, because he felt medical care revolved in large measure around the functions of physicians, and the medical profession could be of great service in the proposed changes if its members offered constructive plans to the State's officials and the people of the State. At the close of his remarks, Governor Warren stated he would be happy to have questions put to him. A round-table conference followed. The importance of having the California Medical Association recognize existing and imminent conditions was emphasized by several speakers.

Subsequent to Governor Warren's departure, Vice-Council Chairman Cline took the chair and opened the meeting for further discussion, which followed.

#### 4. Call for Special Session of C.M.A. House of Delegates:

Upon motion made and seconded, it was voted that a

call be issued for a special meeting of the House of Delegates of the California Medical Association, to be held in Los Angeles on January 4-5-6, 1945. A copy of the call for the special session is attached hereto. (Call was printed in the December issue of CALIFORNIA AND WESTERN MEDICINE, opposite page 281.) The Call was submitted by mail vote to the Councilors and received the favorable vote of every Councilor.

#### 5. Invitation Extended to Governor Earl Warren to Address the House of Delegates:

Upon motion made and seconded, it was voted that an invitation be extended to Governor Earl Warren to address the House of Delegates on January 4, 1945.

Much further discussion followed concerning sickness insurance legislation.

Adjournment followed at 5:00 P.M.

PHILIP K. GILMAN, M.D., *Council Chairman*,  
JOHN W. CLINE, M.D., *Council Vice-Chairman*,  
GEORGE H. KRESS, M.D., *Council Secretary*.

\* \* \*

#### Digest of Remarks by Governor Earl Warren at Meeting Held on December 13, 1944

(Memoranda re: Remarks by Governor Warren of California, at an informal luncheon conference held in Family Club in San Francisco on Wednesday, December 13, 1944, to which Governor Warren had been invited. Luncheon guests included members of Board of Councilors of California Medical Association, Board of Trustees of California Physicians' Service, and other C.M.A. officers and guests. Council Chairman Philip K. Gilman and Vice-Chairman John W. Cline, presided.)

\* \* \*

In the course of his informal remarks Governor Earl Warren brought out the following thoughts:

Governor Warren expressed his appreciation at having the opportunity to talk to representatives of the medical profession, concerning medical care needs of citizens of California; and stated he felt that members of the medical profession, both as physicians and as citizens should have a special interest in medical care plans.

Concerning problems in medical care, Governor Warren said he did not have the answers. The responsibility of finding the answers devolved largely upon the medical profession. To date, the answers had not been given.

Concerning inadequacies in medical care, increasing blame was being placed upon the medical profession by many citizens. The subject had been under such wide discussion that today professional, social and political factors were all a part of the picture.

In any extension of medical care, through coöperation with governmental agencies, financial aid from both Federal and State agencies would come into play.

It was possible that some of the proponents of compulsory sickness plans would prefer to have State plans fail, to make easier the intervention of Federal agencies later.

For himself, Governor Warren felt that the protection and promotion of health among the citizens of California should be more a State rather than a Federal function.

Regarding the Wagner-Murray-Dingell bill as presented in the last U. S. Congress, he believed physicians, by and large, were not in favor of that measure. Nor was he.

It is important that some facts be recognized. Among such, was this,—the average American family of moderate income was not in position to purchase the medical care its members needed and wanted. This want, existing today, will continue to prevail in the future, unless Government steps in and helps spread the costs.

Governor Warren referred to the voluntary Statewide medical service sponsored by the California Medical Association, and operating as California Physicians' Service. He called attention, however, to the fact that at the end of some six years of existence, in California, a State with more than seven million population, the number of beneficiary members (patient members) in C.P.S. was only slightly above 100,000. This then, could not be looked upon as the answer to the people's health needs, even though it was a commendable and valuable beginning, and a possible nucleus for other endeavors.

Governor Warren referred to the C.M.A.'s November, 1943, survey of public relations made by Foote, Cone and Belding, and mentioned some of the interpretative figures that had been brought out by Mr. John Little.

Reference was also made to the sickness legislation proposed as long ago as 1915, when Senator Hiram Johnson was Governor of California. In this State, sickness and health plans had been the subject of much discussion since that time. The rest of the Union was watching California.

Governor Warren stated it was his opinion that the time had arrived when the parties immediately and more directly concerned would find it necessary to get together on a sickness insurance plan that would be acceptable to the people.

When World War II comes to a close, some eleven million men will return to their families. In California, perhaps 800,000 would come under Federal sickness plans, and, with their families, that number would be increased to two and one-half million citizens.

Governor Warren was under the impression, based on information that had come to him, that one or more compulsory sickness bills would be presented to the next California Legislature, which will hold its first meeting on Monday, January 8, 1945, at which time he would address the Legislature.

Governor Warren stated he had seen no drafts of bills, had not been in conference with any groups, but was glad to have the opportunity to express, to physicians, the hope that prior to the convening of the Legislature on January 8th next, information would be sent to him that the medical profession of California would present one or more constructive plans designed to give adequate medical care to California citizens.

Further, he stated he was of the opinion that, if throughout the United States, the various States took the leadership in constructive legislation, members of the Federal Congress would prefer to have sickness and health care be under State rather than Federal supervision.

He felt he should also inform his hearers, that if the next California Legislature failed to provide at least the fundamentals of a Statewide plan for medical care, other groups that were interested would carry the subject to the people, for initiative vote, with chances of favorable approval by the electorate.

Governor Warren closed his remarks by stating that he hoped the medical profession of California would sense its responsibility in these matters, and take the initiative both in the Legislature and in any appeal to the electorate.

Also, he would remain to hear opinions of those present, and try to answer questions put to him.

\* \* \*

Open discussion followed, in which many Councilors and others participated. Among items touched upon were the following:

(a) Voluntary sickness plan is not the answer to the people's health and sickness needs.

(b) It was desirable that the physician-patient relationship be maintained.

(c) A California State agency, through which funds could be collected and disbursed, might be the California Unemployment Commission.

(d) Not desirable to have doctors giving service on payroll basis.

(e) Contracts might be made with nonprofit medical care organizations, C.P.S. an example. However, no monopoly set-up would be permissible.

(f) Would include certain now exempt groups in plan, namely, household employees, agricultural workers and others.

(g) Was in favor of proper compensation to physicians who cared for indigent citizens. Plan should make provision for this.

(h) All licensed physicians and surgeons (M.D.'s and Osteopathic P. and S.) should have equal rights.

Concerning other groups, with different standards, was not prepared to give an answer.

(i) State, County, City and Local governmental agencies must be responsive to Federal suggestions (when Federal aid is given) but not be under Federal control.

(j) Hospitalization provisions, dentistry and other accessory aids, must all be recognized in a large plan.

(k) People of the United States have long looked to California as being in the advance guard in social welfare agencies.

(l) In a governing board of a Statewide plan, say of seven members, four members thereof could be of healing art professions.

(m) Ceiling income level of citizens to be covered, to be a subject of actuarial and other study.

(n) Conceded that medical profession does not want to be regimented.

(o) Medical profession should be the plaintiff by submitting to the Legislature a program for adequate medical care. Should not permit itself to be placed in rôle of defendant.

(p) If medical profession presented no constructive plan, and Legislature passed a bill sponsored by others, then if such measure not vicious, might be obliged to let same become a law.

(Signed) GEORGE H. KRESS, *Secretary*.

(COPY)

STATE OF CALIFORNIA  
Governor's Office  
Sacramento 14, December 28, 1944.

George H. Kress, M.D.,  
Secretary-Editor,  
California Medical Association,  
San Francisco 8, California.  
Dear Doctor Kress:

Governor Warren has received your letters of December 27th enclosing you memoranda concerning his informal remarks at the December 13th luncheon in San Francisco, and a rough draft of the minutes of a Council meeting of your Association.

He has asked me to tell you that he sees no reason why these do not correctly state the substance of his remarks, and correctly state the fact of his presence for the minutes.

He wishes me to express his appreciation for your courtesy in submitting these to him for his inspection.

Sincerely,

(Signed) BEACH VASEY, *Legislative Secretary*.

Call For Special Session  
House of Delegates of the California Medical  
Association  
Notice of Special Meeting

# *To the Members of the House of Delegates of the California Medical Association:*

The Council of the California Medical Association at a special meeting thereof, duly held on Wednesday, the thirteenth day of December, 1944, at San Francisco, California, by the affirmative vote of all members present, as confirmed by official mail vote, constituting more than two-thirds of all of the members of the Council, adopted the following resolution calling a special meeting of the House of Delegates:

*Resolved*, That a special meeting and session of the House of Delegates of this Association, California Medical Association, is hereby called to be held at the Elks Temple, at 607 South Park View (corner West 6th Street and Park View, in the City of Los Angeles, State of California, on the fourth, fifth and sixth days of January, 1945, (Thursday, Friday, Saturday), at the hour of 11 o'clock a.m. for the purpose of:

(a) Considering and acting upon legislative proposals relating to state medicine likely to be introduced by certain groups in the coming session of the California Legislature; and

(b) Formulating and acting upon one or more statewide health service legislative proposals satisfactory to a majority of the membership of the C.M.A. House of Delegates; and

(c) Considering and determining the general policies of the California Medical Association at the forthcoming session of the Legislature with reference to legislation or public policy affecting or concerning medical practice in all its phases, payment for the cost of medical care, and all related matters.

*Further Resolved*, That George H. Kress, the Secretary of this Association, be and he is hereby directed to prepare a written notice setting forth the time and place of meeting and the purposes and objects thereof and transmit the same, signed by him and attested by the President, the Chairman of the Council, and the Speaker of the House of Delegates in the manner and within the time required by the Constitution of the Association.

**SECRETARY'S NOTICE.**—Pursuant to said resolution of the Council, you and each of you will hereby please take notice that a special meeting of the House of Delegates of the California Medical Association will be held at the Elks Temple, at 607 South Park View (Corner West 6th Street and Park View), in the City of Los Angeles, State of California, on the fourth, fifth, and sixth days of January, 1945, (Thursday, Friday, Saturday), at the hour of 11 o'clock a.m. of said days, and that the objects and purposes of said special meeting are those objects and purposes set forth in the resolution of the Council, above quoted.

The delegates and alternates who shall be eligible to be seated in the House at said special session shall be those delegates and alternates who were eligible to serve on the seventh day of May, 1944. (At the California Medical Association annual session at Los Angeles.)

(Signed) GEORGE H. KRESS,  
*Secretary of the California Medical Association.*

Attest to Official Call:

LOWELL S. GOIN,  
*President of the California Medical Association.*

E. VINCENT ASKEY,  
*Speaker of the House of Delegates of the California Medical Association.*

PHILIP K. GILMAN,  
*Chairman of the Council of the California Medical Association.*

San Francisco, December 13, 1944.

### Warren Will Seek State Health Bill

#### Governor Favors Compulsory Plan of Employer-Employee Contributions

Sacramento, December 29.—Governor Warren today announced he will sponsor a measure at the coming session of the Legislature providing "prepaid medical care through a system of compulsory health insurance" for California citizens.

Enactment of this program would put California in the forefront among the States; none has such a plan.

The program would be financed by contributions by both employers and employees. A program of protection, likewise, would be arranged whereby self-employed and all other qualified residents of the State could, by making contributions, come under the program.

Conferences already have been held by the Governor with the council of the California Medical Association and the House of Delegates of that organization will act on the Governor's plan at a Los Angeles meeting January 4-6.

"I am not for State medicine," said the Governor, in making clear the difference between his proposal and any scheme to put the doctors on a State pay roll and "pay for the medical and hospital expenses of the people out of public funds."

#### Levy of 1½ Per Cent

"My information," he said, "is that we can do the job by a 1½ per cent contribution each from employee and employer."

Present health insurance systems which met the standards set up in the proposed State compulsory health insurance plan would not be interfered with.

The Governor said it "may be necessary for the State to stabilize the health insurance fund during the first biennium," while a backlog of contributions builds up.

Warren said there appear to be "1,500,000 persons who are medically substandard in California." He said 38 of every 100 Californians called up by selective service had been rejected "because of physical or mental defects."

Warren said he had become convinced that "voluntary health insurance systems will not work because everybody will not join."—Earl C. Behrens, in Los Angeles Times, of December 29, 1944.

### State Health Bill

#### Governor Proposes Compulsory Insurance Plan for California

Sacramento, Dec. 29.—(U.P.)—Governor Earl Warren today announced he will submit to the California legislature meeting next month a plan of compulsory health insurance financed by a payroll tax on both employers and employees.

The Governor said the insurance plan would cover both contributors and their families and would provide for payment of costs of medical and hospital care. He said he believed the expenses for purchases of drugs and perhaps for basic dental care also should be included.

The plan probably can be financed by a 1½ per cent payroll tax on both employees and employers, Warren said, although he emphasized that the rate cannot yet be estimated exactly.

"I am not for State medicine," Warren said, "where doctors are put on the public payrolls and care is paid for from governmental funds. I don't believe in that system. . . . I do want to spread the cost of medical care by compulsory contribution of workers and industry, both of whom would be beneficiaries."

He pointed out that there have been attempts to set up health insurance plans in California for 30 years, culminating in the establishment of the California Physicians' Service in 1938, but that they had not been com-

pletely successful because they do not cover enough persons.

(A Statewide prepaid medical insurance plan for all workers covered by unemployment insurance is a major part of the California CIO legislative program, CIO Secretary Mervyn Rathborne said when asked to comment on the Governor's proposal. The CIO, Rathborne said, has prepared legislation along the lines recommended by Governor Warren for submission to the coming legislature. The State CIO executive board will meet January 11 to 14 in Oakland to put the finishing touches on their complete legislative program.)—Editor People's World.—California People's World, December 30, 1944.

### Governor Warren to Ask Compulsory Health Insurance for State

Sacramento, Dec. 29.—(U.P.)—Governor Earl Warren today announced he will submit to the California Legislature meeting next month a plan of compulsory health insurance financed by a pay roll tax on both employers and employees.

The Governor said the insurance plan would cover both contributors and their families and would provide for payment of costs of medical and hospital care. He said he believed that expenses for purchases of drugs and perhaps for basic dental care also should be included.

The plan probably can be financed by a 1½ per cent pay roll tax on both employees and employers. Warren said, although he emphasized that now the rate cannot be estimated exactly.

#### Not State Medicine

"I am not for State medicine," Warren said, "where doctors are put on the public pay rolls and care is paid for from governmental funds. I don't believe in that system. . . . I do want to spread the cost of medical care by compulsory contribution of workers and industry, both of whom would be beneficiaries."

He pointed out that there have been attempts to set up health insurance plans in California for 30 years, culminating in the establishment of the California Physicians' Service in 1938, but that they had not been completely successful because they do not cover enough persons.

#### Pay Roll Tax

The pay roll tax, the Governor said, probably would be collected by the State Department of Employment, while the Department of Public Health would administer details of the plan with advice of a council representing employers, employees and physicians.

He emphasized that the plan would require setting of a scale of fees for different types of medical services. However, he declared it would "not change the relationship of doctor and patient and would provide for freedom of choice of physicians," he said.

"I'm convinced," Warren said, "that the time has arrived when we must in order to fill our obligations have such a system. We have talked about the matter in California for years. . . . But, we never have gone very far beyond the study and talk stage although we have known that adequate medical care and hospital service is beyond the reach of the average citizen."

#### Figures Cited

"Everybody has said for years that service is available only to the wealthy and the indigent, and there is considerable truth in the statement."

Citing figures of the State Selective Service System as showing a need for an improved health program, Warren said that of every 100 California men examined for induction into the armed services 38 have been

rejected on account of physical or mental deficiencies.

In all, he said that 374,000 men between the ages of 18 and 36 have been found defective. If the figure were projected, he said, it means that about 1,500,000 California residents are below standard in health.

#### Startling to Some

"I'm sure that there are many people who will be startled at the idea of compulsory health insurance," Warren said. "But there are always people startled at new things even when they have to be done."

The Governor said that it might be necessary for contributions to start some time before benefits can be inaugurated, or the State might guarantee the benefit fund during a trial period.

The coverage should be broader than present coverage of unemployment insurance, taking in self-employed and other groups, Warren said. He added that it might be wise, at least at first, to place a ceiling on the income level of persons covered in the plan.

Physicians, he said, could elect to give service under the plan and conform to a rate schedule or not, as they pleased.—*Stockton Record*, December 29.

#### Warren Urges Compulsory Health Plan

Sacramento, Dec. 29.—(I.N.S.)—A system of prepaid medical care through compulsory health insurance for Californians was recommended today by Governor Earl Warren.

The proposed health insurance would cover families of workers contributing to the fund as well as those paying the insurance, and, in addition, would take in groups not now covered by unemployment insurance, such as the self employed.

The Governor made his disclosure at a third in a series of news conferences designed to give a "preview" of the legislative program to be recommended to the 1945 session.

Governor Warren declared he was convinced the time has arrived when California must inaugurate such a system to raise the State's standard of health.

#### Contributions Plan

Warren said that he believed a "reasonably sound" program could be financed through compulsory contributions from wage earners and employers of 1½ per cent each.

In setting up such a system, the Governor added, he did not want to see State medicine, which he described as a system under which doctors are placed on the public payroll and medical care paid for out of public funds.

"I don't want to change the professional relationship of the doctor and patient," Warren explained. "I want freedom of choice to exist for both. But we do want to spread the cost of medical care by compulsory contributions of workers and industry, both of whom will be the direct beneficiaries of such assistance."

In citing the need for compulsory health insurance, the Governor estimated at least 1,500,000 Californians were in sub-standard health.

He based his estimate on recent reports of Selective Service headquarters, which showed that to date more than 374,000 youths between 18 and 36 have been rejected by the armed forces because of mental and physical deficiencies.

These figures of the draft rejections, Warren declared, present "an amazing and shocking story."

"I am sure," said the Governor, "that there will be a lot of people startled by the thought of compulsory health insurance, but I think we are always startled by doing new things even though we have known they were necessary."

Warren said there was a great need for such a system and in his opinion, "fear should not deter us from trying to inaugurate it."

Although admitting details of the proposal have not been worked out—and that these details generally would be worked out by the legislature—the Governor said it was probable most of the contributions would be collected through the State unemployment insurance system.

He said that probably the State Department of Public Health should administer the program through a separate division, with a State council on health insurance setting general policies.

This council should be made up, Warren said, of representatives of interested groups, such as workers, employers and the medical and dental professions. He added that the proposed health insurance program probably could well include basic dental care but just how extensive would be a problem to be worked out later.

Under the system, doctors would work on a fixed fee basis, with the patient free to choose his own doctor and hospital.

Declaring Governor Earl Warren's proposal for compulsory health insurance is "a matter of grave importance to the entire future of the medical profession," Dr. John W. Cline, chairman of the executive council of the California Medical Association, disclosed today a special meeting of the Association's House of Delegates has been called.

The meeting, covering January 4, 5 and 6, will be devoted to "discussing the Governor's and various other health plans, and it is possible that a specific plan will emerge from it," Dr. Cline said.

"It was our understanding," he said, "that the Governor wished the medical profession to promulgate a plan, and it is for that purpose, and for the purpose of discussing the entire field of medical insurance and possibly promulgating a plan, that the House of Delegates has been called into session."

"Approximately 150 delegates from the entire State will attend."—Robert C. Weakley, Staff Correspondent *International News*, in *San Francisco Call-Bulletin*, December 29, 1944.

#### Compulsory Health Service

Governor Warren strikes out boldly into a progressive but highly controversial field with his announced intention of submitting a compulsory health insurance plan to the forthcoming session of the Legislature.

No doubt he was encouraged to take the step by the growing favor of the medical profession for a modified brand of State medicine, following experience with the California Physicians' Service, a voluntary plan operated by the doctors themselves. In some respects this plan has worked well, but it has failed to attract a large enough representation of low-paid workers among its beneficiaries to be worthwhile as a broad social agency.

But also, the Governor's move doubtless was stimulated by knowledge that the CIO is determined to put through legislation for a Statewide system either by the 1945 Legislature or by popular vote at the next general election. The doctors, too, were quickened to action by fear that labor would achieve something more akin to actual State medicine than they desire.

Regardless, however, of the incentive or source, the proposal will meet with enthusiastic support in many quarters. Not until the plan actually is drafted and the details known can it be appraised, but the principle will be subscribed to by thousands of citizens who long have felt inequalities of the cost of medical care.

In effect it is a compulsory saving arrangement where-

by employer and employee will join in establishing a fund under State management from which medical expenses may be provided for workers and their families within a certain income group. Presumably it will cover about the same number as the present unemployment insurance, although the Governor suggests a larger coverage may be found desirable. Broadly the set-up and procedure will follow the unemployment compensation insurance practice, but with a liberalizing feature permitting beneficiaries to choose their own physicians, hospitals and other services. This avoids the medical profession's chief fear of State medicine—the creation of a body of State doctors on the public payroll. Physicians will be free to give service under the plan at established rates, or not, as they please.

Properly organized, with these provisions, the system should be no threat to the independence or earning ability of the medical profession. It would force workers to do what they ordinarily do not do—save money against the inevitable need for medical service. It would encourage them to seek medical service whereas now they avoid it on account of the expense. It would guarantee doctors full collection of their bills and probably yield them more income at lower rates per service rendered.

California has been a leader among the States in public welfare legislation. Its provisions for the aged, the blind, for indigent children, for tubercular sufferers, for injured industrial workers and for the unemployed have been more liberal than those of other States. Governor Warren is following the illustrious traditions of the State in proposing compulsory health insurance as the next step in California's enlightened social program.—Editorial in *San Francisco News*, December 30, 1944.

#### Governor Warren to Council Chairman Gilman

STATE OF CALIFORNIA

Governor's Office

Earl Warren, Governor

Sacramento (14), January 3, 1945.

Dr. Philip K. Gilman,  
President-elect,  
California Medical Association.

My dear Dr. Gilman:

The approaching session of the Legislature is so near at hand that it will be impossible for me to attend the meeting of the House of Delegates of the California Medical Association at Los Angeles, in accordance with the kind invitation of Dr. George Kress to address the gathering. I sincerely regret my inability to discuss the all-important problem of health insurance with those who are guiding the destiny of your profession, because I believe the time for constructive action on this subject has arrived.

We have been talking about it for many years, the first Health Insurance Commission in California having been established by the Legislature exactly thirty years ago. Since that time interested groups, including your Association, have advanced proposals in the State Legislature, but none of them progressed beyond the talking stage. It is my opinion that through the passage of years and the development of a finer special conscience, most people are agreed that if we are to raise the health standards of our people to a plane consistent with our hopes for the future, we must have a system of health insurance that will spread the cost of medical care over the lifetime of those protected through regular contributions by themselves and the industry which they support. Re-

cent surveys, including that conducted by your Association, have shown that the public is anxious and ready for action.

I believe that this realization has been crystallized by the startling and disappointing results of the Selective Service general physical examinations, which show that even in California, where we pride ourselves on our humanitarian institutions and our health standards, 38 out of every 100 boys examined were of necessity rejected because of physical or mental defects. Reduced to numbers, this means that 374,000 of what we generally consider to be the flower of the land, between the ages of 18 and 36, were rejected as unfit for service in the armed forces of our country. If we project this situation so as to include males who are in the younger and older groups, as well as to the other sex, the number of physically unfit becomes appalling. I believe most of us have hoped in years gone by that improved standards of living, new insurance practices, industrial health programs, etc., would permit us to have prepaid medical care on a voluntary basis. Many laudable programs have been initiated and chief among them is your own California Physicians' Service, but after more than six years of existence and with the blessing of your Association it has only enrolled something over 100,000 persons. To me and to many others, this means that such voluntary systems, desirable as they may be, cannot in and of themselves keep pace with public need and with the crying demands of our people. If this is true, it leaves but one alternative, and that is a system for prepaid medical care through Statewide health insurance.

In order to avoid misunderstanding, I would like to state what is not included, as well as what is included in this suggestion: First, I do not favor State medicine. By "State medicine," I mean the employment by the State of physicians to treat all persons, at public clinics or otherwise, at State expense. Second, I do not favor any plan which will destroy the professional relationship of physician and patient, or the right of choice of either in that relationship. Third, I do not favor political interference with the practice of medicine.

On the contrary, I want every person to have the right to select his own physician and every physician to have the right to treat whom he desires. I want medical practice to be left entirely uninhibited to pursue its present professional methods under a system whereby the cost of medical services for unemployed individuals and their families may be paid from a State fund to which they will contribute regularly. I am not committed to all the details of a plan, but I do want California to assume its full responsibility of maintaining proper health standards for all our people. I am hopeful that the details will be supplied by the interested groups, and particularly by your own which in my opinion rightfully is entitled to assume leadership in the solution of such an important problem of public health.

It was this belief that prompted me first to discuss the matter with you at Oak Knoll Hospital in November and then later with the Executive Committee of your Council at San Francisco. Needless to say, I was heartened by the fair reception which both you and your Council accorded the proposal.

The things that I believe should be incorporated in any such plan of health insurance are as follows:

1. A fund raised through payroll contributions payable in equal amounts by employers and by employees and collected wherever possible in the same manner as unemployment insurance contributions.
2. The administration of the fund to be by a medical director heading a division in the Department of Public Health.
3. The policies of the system to be formulated by a State board on which there should be representatives of

the medical and dental professions, of employers and employees.

4. The right of every person to choose his own physician or hospital, both of which are to be compensated on a fee basis as distinguished from a salary or capitation basis.

Here is an urgent need of the people of the State of California. No group is more vitally concerned than the medical profession. No group is more called on to find its solution. No group is better qualified to evolve a plan to meet the problem. I sincerely hope that as President-elect of your Association you will join with me in seeking the cooperation of the medical profession in working out the plan for which the people of our State are calling.

With best wishes, I am

Sincerely,

(Signed) EARL WARREN, Governor.

#### Health Insurance on Way, Union Leaders Tell Doctors

##### *Regimentation Seen If Medical Men Don't Step In*

Directing a message to the 10,000 licensed physicians in California, Eugene Boyd, an A.F.L. representative at a California Medical Association meeting here yesterday, advised them that if they wish to preserve "personal initiative" in medical practice they had better get out quick and fight for it.

"If the medical profession does not step in, it certainly will be regimented—make no mistake about that!" Boyd, a building trades union leader, told the doctors. He had been invited to address the meeting, specially called to consider current campaigns to set up State compulsory health insurance. He told the medical men that regardless of the name under which compulsory health insurance is put forth, "it is still socialized medicine."

#### Other Speakers

Boyd was the first speaker after Albee Slade and Mervyn Rathbone, State C.I.O. leaders, had explained the \$250,000,000 compulsory health insurance plan which the C.I.O. hopes to have the coming Legislature set up.

#### A.F.L. Views

The A.F.L. man made it plain that A.F.L. leaders believe the time is here to provide far more medical care than generally is available, especially to persons of moderate or low income. He told of a vast but somewhat nebulous Federal plan for health insurance that is being promoted, said Gov. Warren has been studying this, and that the California A.F.L. is awaiting further moves in that direction by the Governor. He expressed the hope that the association will provide the leadership for what is to come along this line.

#### C.I.O. Ideas Outlined

Slade principally outlined the C.I.O. plan for compulsory health insurance. He said it is not socialized medicine and that the C.I.O. opposes socialized medicine. He offered it with a solicitation of help from the association, which had invited the C.I.O. to expound the plan to the doctors.

As understood by some of the doctors who have studied the C.I.O. plan, it would levy a new tax on a worker's income up to \$5,000, another new one on an employer's pay roll and would draw on taxpayers in general for funds to finance the system. The public would pay the tax for the poor.

An extensive network of selected union men, employers and so-called "public representatives" and doctors would be set up to cover the State with administration machinery on a detailed scale.

"Free" medical care in homes and in hospitals would then be provided for eligibles. Doctors would receive their pay from the State.

#### Service for 6,000,000 California Citizens

Slade estimated that the "free" service would be extended to approximately 6,000,000 California residents to begin with and would provide "medical service on the basis of need instead of on ability to pay."

"Gov. Warren has found that health insurance is politically and socially the order of the day," Slade told the doctors.

#### Farm Bureaus

Von T. Ellsworth of the California Farm Bureau Federation, another invited speaker, told the doctors that "the time for action has arrived." He said he does not believe that voluntary health insurance has yet had a fair trial in this State. He spoke against compulsion and for extended medical facilities to persons not now procuring it, especially because of its high cost. Ellsworth believes some of the new social forces now at work are "going too fast." He wants further development of a voluntary plan.

#### State Board of Public Health

State Health Director Wilton Halverson referred to the Federal health care program promoted in Congress and warned:

"None of us believe that a medical program operated from the Federal level can ever give the best care. The leaders of the profession must do their best to develop a program to meet the social needs of the people but they must not be tied down with governmental red tape."

Throughout the day, various resolutions and proposals were discussed by the doctors, numbering some 200, and today they are to arrive at an association policy on the subject. Sessions are in the Elks Club.—Los Angeles Times, Saturday, January 6, 1945.

#### Resolutions Adopted by the C.M.A. House of Delegates on January 7, 1945, at the Special Session of the House of Delegates.

(COPY)

(Copy of the Foreword and Resolutions adopted by the House of Delegates of the California Medical Association, in special session in Los Angeles on January 4, 5, and 6, 1945.)

\* \* \*

Los Angeles, January 7, 1945.

To the House of Delegates of the California Medical Association:

Your Resolutions Committee submitted a preliminary report at yesterday's meeting (January 5, 1945) and it will be assumed that the members of the House have in mind the general tenor of that report. At yesterday afternoon's session, twenty (20) resolutions were presented, in addition to those previously submitted, and all these your Committee had to consider between last evening's hour of adjournment and this morning's meeting, which was scheduled to begin at 9:00 A.M. Your Resolutions Committee remained in session until after one o'clock this morning, and it now submits to you this supplemental report.

Before proceeding with consideration of specific resolutions we believe it advisable, briefly to review the immediate circumstances leading up to this special meeting of the House of Delegates of the California Medical Association, so that the House may bear in mind one fundamental point, which is, that the House must give a specific answer to a specific question.

Early in December, 1944, His Excellency, Governor Earl Warren conferred with the officers and councilors of the California Medical Association and stated to them in substance that he favored and urged the establishment by law of a system for the distribution of the costs of medical care, to be financed, if necessary, through new and additional pay roll taxes. Governor Warren stated that he had an open mind as to the details of any such system. He requested the California Medical Association to inform him of the type of tax-financed medical care plan, if any, that the Association would approve.

Subsequently, officers and members of the Association have held informal conferences with representatives of organized labor and a representative of the California Farm Bureau. Representatives of labor and a representative of the Farm Bureau have appeared before the Council and before the delegates at this special meeting of the House of Delegates. The Governor of the State of California has asked of us a question. We must now proceed to answer it.

Most of the resolutions submitted by members of the House and considered by the Committee contain various answers to the Governor's inquiry. Your Committee felt that to consider each resolution separately would involve both duplication and unnecessary prolongation of this special three-day session. Therefore, your Committee has prepared a substitute resolution containing a specific answer to the question that has been propounded to the Association. The resolution proposes a plan for State assistance in the solution of the problem of the distribution of the costs of medical care, but it does not contain any acceptance, direct or indirect, of the basic provisions of any known compulsory health insurance system.

Your Committee recommends that this House of Delegates express its appreciation of the sincerity of purpose of the Governor, and the representatives of labor and of agriculture in their proposals looking toward a solution of the problems before us. We recognize with gratification that an important forward step has been taken in the furtherance of mutual understanding and cooperation between the California Medical Association and the leaders of the public its members serve. It is our earnest desire to seek the continued advice and cooperation of all parties having interests in the solution of our mutual problems.

Your Committee now submits the following resolution:

*Resolved*, That the California Medical Association is of the firm conviction that no fundamental and revolutionary change in the practice of medicine should be made under present wartime conditions. If disruption occurs in the rendering of medical service, the result can well be a catastrophe for the people of the State. That major disruption would occur if health insurance were made compulsory by the State is self-evident, regardless of approval or disapproval by the doctors of a new system in principle. This is true for two reasons: The doctors remaining in civilian practice, after over 3,000 or approximately one-third have gone into military service are barely able now to provide medical service for a greatly expanded population and greatly expanded industry and they do it by working to or beyond the limit of sustained endurance. If, now, they are forced to go through a period of change to a new and unfamiliar system of practice, medical service to the people will break down. This is not theory. We know from experience with California Physicians' Service that the process of educating doctors and patients, to say nothing of administrators, to operate under an unfamiliar system is not accomplished overnight.

Furthermore, from experience of California Physicians' Service, in the War Housing projects where a full coverage plan was in operation, it was found that

the demand for service was vastly increased under a complete prepayment system—in fact as much as doubled. Without arguing how much increased service is or is not desirable, the plain fact is that the doctors are doing all they can now and a large increase in demand for service will with absolute certainty break down medical care in California; and be it further

*Resolved*, That the California Medical Association cannot endorse any system of compulsory health insurance which has thus far come to its attention; and be it further

*Resolved*, That the California Medical Association is equally convinced that there is an existing problem with respect to the distribution of the costs of health services and therefore, its position with respect to such problems must continue to be a positive and progressive one; and be it further

*Resolved*, That as such a positive and progressive step toward the ultimate solution of the problem, the House of Delegates of the California Medical Association hereby proposes the following program which it believes to be both desirable and feasible under all existing circumstances:

(a) An increase in the benefits of the California Unemployment Insurance Act, without increasing pay roll taxes, to provide cash indemnities to wage earners when ill or injured through non-industrial causes. Such cash indemnities would be primarily used for the payment in whole or in part of incurred hospitalization costs. This proposal is feasible because the present California Unemployment benefits and the estimated cost of adding cash indemnities can well be financed within the existing unemployment tax structure.

(b) The California Medical Association is wholeheartedly in favor of the principle of distribution of the costs of medical care by means of prepayment, and its sincerity in this regard is evidenced by its expenditure of no inconsiderable money and effort for the development of California Physicians' Service, and that California Physicians' Service has been offering to the public a statewide, nonprofit prepayment plan for the past five and a half years.

The California Medical Association respectfully insists that it is not an informed statement to characterize California Physicians' Service as a "failure because it covers only about 125,000 people." A brief review of its enrollment experience presents a fairer picture of its present status and future prospects. After its administrative organization was ready to operate in 1939, it took three weeks to enroll the first ten members. Rate of enrollment in its first four years averaged about 1,000 per month. Now, with its more advanced "seasoning," with improvement in compensation to doctors, with better public knowledge of and confidence in it, rate of enrollment of new members has risen to approximately 12,000 per month in the last four months of 1944. If it is fair to judge the future by past experience, California Physicians' Service is, just at this time, entering upon a period of very rapidly increasing expansion.

The California Medical Association respectfully insists that instead of characterizing California Physicians' Service as a failure because it covers as yet an insufficient number of people, the State Government, Management, Labor and Agriculture should implement and assist California Physicians' Service to attain its objectives.

Such assistance could well be a reduction of the employees' portion of the California Unemployment tax for those employees who have joined California Physicians' Service or any other equivalent service. To illustrate this proposal—under it, an employee enrolling in California Physicians' Service (or in one of the Blue Cross Plans) would have a smaller sum deducted from

his pay check each month than he would if he failed to join. The amount of this reduction would be small, but its smallness is not important because the existence of any incentive will unquestionably act as a tremendous aid to the growth of voluntary non-profit plans. It may be claimed that this cannot be done without increasing existing taxes. Therefore, the following information is of importance. The present California Unemployment Tax consists of 3.7 per cent of all payrolls, 2.7 per cent paid by the employer, 1 per cent paid by the employee. This tax fund is collected under the present law for the sole purpose of paying cash benefits to people unemployed through loss of work. Since the inception of the California Unemployment system, the benefits paid out have been less than 1/3 of the amount of the taxes collected. Even in pre-war years the benefits paid out averaged not over half the taxes collected. Therefore it is apparent that a tax reduction to encourage medical coverage can be added to the Unemployment Act without jeopardizing the solvency of the fund and without adding to the tax burden. California is in an advantageous position in this regard because it is one of the few states that impose a 1 per cent unemployment tax on employees in addition to the 2.7 per cent employers' tax. It is this 1 per cent which has resulted in the California fund becoming extremely large and further results in the feasibility of our suggested plan. For instance, the present surplus is \$621,708,167.89.

(c) A more rigid enforcement by the State of the various existing disease preventive measures and other public health laws should be undertaken. By this means, already at the command of the State, great strides can be made toward the reduction of the incidence of illness and disease. It must not be forgotten that all reductions in the incidence of illness decrease the cost of medical care. Better enforcement of existing preventive measures relating to tuberculosis, contagious diseases and, specifically, venereal diseases would reduce the incidence of these diseases and illustrate this point; and be it further

*Resolved,* That recent proposals to establish some form of compulsory health insurance in this State have come at the last minute without any opportunity for adequate consideration and planning by any of the many interested groups or sufficient time for interchange of opinions and knowledge. Very considerable progress has been made in defining objectives in recent meetings between representatives of the medical profession with the Governor and other groups, and it is the belief of your committee that such meetings and further exchange of ideas should be undertaken immediately, and continued until a definite conclusion has been reached.

I move the adoption of this resolution as a whole.

It is further suggested that the California Medical Association specifically and immediately invite representatives of the Government of the State of California, representatives of business and management interests, representatives of Labor, representatives of agricultural organizations, representatives of the dental profession, representatives of hospitals, and representatives of allied medical groups to joint conferences for the purpose of arriving at a complete and comprehensive plan to cover the entire problem of health service in California.

I move the adoption of this section of the Committees' report.

During the deliberations of the Committee, and from the study of the resolutions submitted, the Committee has formulated certain basic principles that are inherent in the success of every prepayment plan of health serv-

ice. These principles are fundamental. They may be enumerated as follows:

1. Absolute freedom of choice of physicians by the patient must be guaranteed;

2. Payments for service rendered must be on the basis of fee for service as opposed to capitation, in payment of the physician.

3. Unhampered medical control of all professional service.

I move the adoption of this section of the committees' report.

#### *Committee on Resolutions*

by

Howard W. Bosworth, M.D., Los Angeles, Chairman.

Jay J. Crane, M.D., Los Angeles.

G. D. Delprat, M.D., San Francisco.

Walter Beckh, M.D., San Francisco.

Dwight H. Murray, M.D., Napa.

#### **Health for All**

Governor Earl Warren was tired of hearing Californians talk about the public health problem. He was tired of that old saying that "medical care and hospital services are available only to the wealthy or the indigent." He whipped up a plan which he announced last week he would present, with pressure, to the next Legislature.

The plan: All employed Californians (and eventually, their families) would be covered by compulsory health insurance which would be financed by docking 1½ per cent of their checks each pay day. Another 1½ per cent would be contributed by their employers.

Such little details as whether or not to fix price ceilings on medical services would have to be worked out by medical men and legislators, but the Governor was certain of one thing: His plan would leave patients free to choose their physicians and physicians free to practice where they please.

If the Governor's plan should be adopted—and health officials were speaking kindly of it last week—California would be the first State in the Union to make health insurance compulsory.—*San Francisco Chronicle*, January 7, 1945.

#### **War Tosses Us a Challenge, Warren Tells Legislators**

Sacramento, Jan. 8.—Here is the condensed text of Governor Warren's message to the 1945 Legislature:

I welcome you to Sacramento. In these trying times we can together do a better job for the people of our State than I can possibly do alone. . . .

We meet as representatives of a people who are conscious of the disruptions, the distortions, the congestions and the sorrows of three long years of war. They look to us for a steadying influence. . . . In the midst of these terrible strains, and they will of necessity increase, the people have the right to look to us for prompt decision in all matters concerned with the war effort.

They have the right to expect us to plan that our war-produced aggravations do not take permanent root. They expect us to start cutting away the handicaps to social and economic progress in the days of peace to come. . . .

There is much for us to do. There are many fields for us to plow together—fields that will produce rich crops of human betterment for our people—fields that are not in the zone of partisanship, but which are the common concern of all men. . . .

#### **Government Is Sound**

It is in this spirit, as well as in accordance with the Constitution, that I report on the condition of your State, the status of its Government and the needs of our people.

First, I report to you that your Government is sound

—sound in finances, in integrity and in conformation to the spirit and the policies established by your honorable body. . . .

#### Prepaid Medical Service

For many years California has been courageous in its undertakings in the field of humanitarian service to her citizens. Thirty years ago we started a movement for health insurance. It is now generally agreed that we cannot bring proper standards of health to the people of every community through voluntary programs. In spite of all our haphazard efforts, the only people who are certain of receiving adequate medical attention today are those who are wealthy, and those who are indigent and forced to accept charity. The great mass of our people are unable to pay for proper medical care when adversity strikes.

But it remained for the Selective Service to demonstrate the sordid results of neglected health. Even in California, 38 out of every 100 of our boys who were called to the service of their country were rejected because of physical and mental defects. In figures this adds up to 374,000. The total cost of the continuance of these defects and illnesses to our State is enormous. Everyone must be concerned. The fact is that most of these defects could have been prevented or cured by adequate and timely medical care.

It is my recommendation that you take action at this session of the Legislature on a program which will bring adequate medical care to the people of our State on a prepaid basis. It is my suggestion that this be accomplished by building a fund, through payroll deductions from both employer and employee, from which the costs of medical care can be financed. Such a program will pay dividends to everyone.

In our efforts to build an enlightened program, I believe we must make certain, both for the advancement of medical science and for the best interests of our citizenry, that the professional relationship of doctor and patient be a matter of free choice. We do not want to put the medical profession on the public payroll. We do not want to deprive the individual of the right to select his own physician. Our major purpose should be to spread the cost of medical care among all the people of the State.

There is no state in the Union better able to undertake such a humanitarian program than California. I am convinced that if we are to keep abreast of needs in the services which we afford our people, we must start on this program immediately. . . . *San Francisco News*, January 8, 1945.

#### Governor's Compulsory Health Insurance Bill

By Earl C. Behrens, Political Editor, *The Chronicle*

Sacramento, Jan. 10.—The Governor's bill for prepaid medical care under a compulsory health insurance system will be the No. 1 measure on the Warren program at this session.

A bitter controversy is brewing over the bill and efforts may be made to sidetrack it in legislative committees.

Warren told newsmen he and his staff worked late last night on the details of the measure. . . .

#### The Action Stage

The Governor will ask that there be no delays nor any more study committees on the health insurance program but that a bill be enacted at the 1945 session. He said today "we are in the action stage" and "we've been studying the subject for 30 years."

Warren said any further delays "would defeat the purpose of health insurance."

To date the Governor officially has received no help from the California Medical Association although individual leaders of that organization have discussed the program with the Governor.

"The bill will incorporate all elements of health insurance and I know of no reason why the Legislature cannot arrive at some judgment on it at this session," Warren said.

#### Worker's Indemnities

He said the suggestion from the House of Delegates of the State Medical Association that a system of worker's indemnities in case of illness be substituted for a complete health insurance program would not be sufficient.

Warren cited California's leadership in progressive legislation. "This program is in keeping with California's liberalism," he said.

The Governor said he was awaiting appointment of the members of the committees in the Senate and Assembly before making a choice of the members who will be asked to handle the health insurance legislation. The chairman of the committee handling public health may be asked to steer the Warren proposal. . . . —*San Francisco Chronicle*, January 11.

(COPY)

#### The Governor's Legislative Program

Information Bulletin: Merchants and Manufacturers Association for Better Employment Relations

January 10, 1945.

In his legislative program sent to the Legislature by Governor Warren were included the following, which directly or indirectly concern labor relations:

(1) A compulsory payroll tax on employers and employees of 1½ per cent, to be collected and disbursed by the State to provide medical and hospital service, apparently, according to the press reports, available for all our people. There will be a limitation upon the amount of individual pay to be so taxed, but that is not yet named.

Until the Governor's measure is actually introduced it cannot be properly appraised. But in the meantime, thought can be given to these inquiries.

(a) What factual demonstration has been made as to the benefits apt to be derived from this compulsory contribution? In a previous statement it was said that the draft showed a great many young men physically below par. That is true, but how many of these men would have been made physically fit by this proposed compulsory tax-pay medical system? How much of the unfitness was due to the people exercising their individual freedom, careless of their own physical welfare, and who would not seek or follow medical advice?

(b) Why should the employer be singled out to contribute to the welfare of the whole community without any definite assurance of benefit to him? Why should employees, as such, be taxed without their consent for the community benefit and without assurance as to any individual need, or individual willingness to make such contribution?

(c) No assurance is given that any such contributions can be deducted from the Federal income tax, the present provision of the law being that only amounts paid out for medical and hospital service in excess of 5 per cent can be so deducted. How much then will an employer, for example, who is now in the high-income brackets, have to pay out of what is left of his net profit?—especially if his payroll is half or more of his total operating expenses? How about the employee who earns say \$2,500 per year and who will be obliged to contribute \$37.50? What is his view as to the necessity for such contribution as against a possible benefit during that year?

(d) What will be the cost of administration by the State? What will be the procedure under which doctors and hospitals will get their pay? How and when? To what extent will their bills be subject to audit and other control by a State bureau?

(e) A very great many employers in this State already have long-established medical and hospital service with the cooperation of the employees, and developed through many years of experience. These voluntary associations are operating satisfactorily, and giving service to a very large number of people, running probably into the hundreds of thousands. What will be the effect upon them? The doctors have also established medical and hospital services on a voluntary insurance basis. Will these be disrupted? What will be the effect upon the usefulness of the physician? The hospital? Cannot these voluntary efforts be encouraged and increased?

(f) What safeguards are to be placed around this fund rising from compulsory taxation, with respect to its expenditure? Any limits on the individual demand? What will constitute eligibility for benefits? Is it to be upon a pay-as-you-go basis, or represent another "reserve" appropriation of taxpayers' money as against an undetermined need?

(g) It is hardly necessary to suggest in this connection that the present war measures of taxation cannot be permanently borne by our people. History has demonstrated that conclusion. They must be revised downward after the war. Is it wise then to add say \$200,000,000 annually to that burden in this State at this time without knowledge of our postwar tax problems?—arising out of needs imperative in nature?

These are questions for you to consider and wherever practicable to ask your employees to consider. Then, the most important question of all—the very broad question of *how far* the State should go in making attempt to provide for the individual welfare of all its citizens through taxation either of certain classes, as in this instance, or of all. There are many ills that flesh is heir to; but can they be remedied by taxation? Where is State dependence to be substituted for individual self-dependence?

Then there is the final, as yet unanswerable, question—what will be the further call upon our incomes to win the World War? Whatever the merits of any new measures for using the taxpayers' money may be, is it not wise to defer them until we have victory and with it some measure of our postwar problems?

If these questions be bluntly put, it is with the hope that your thought individually may be aroused—and your conclusions aid in getting informed action.

(2) The other measures include extension of maximum unemployment insurance from 23 to 26 weeks, reduction of the waiting period before such payments begin from 2 weeks to 1 week, extension of the coverage of unemployment insurance to all employees, and other suggestions that do not directly relate to labor relations.

You will be promptly advised as to all proposed legislation affecting labor relations as fast as copies of such measures are available.

### Medical Care

Whether Governor Warren's suggestion to the Legislature for a public medical care program opens the door to "State medicine" depends largely on the attitude of the medical profession.

Sooner or later there is going to be some sort of public program to provide medical care to the large majority of the population neither affluent enough to pay for the best nor indigent and so entitled to free care.

It can be guided by the medical profession so as to

preserve the desirable relation of doctor and patient and protect the interests of both. If the medical profession shuns it, politicians will do the job and, as usually, with less satisfactory results. One of these will be "State medicine." Some other points in the Governor's suggestion, which he does not state arbitrarily, may be open to debate. The first and most important point is what the doctors will do about it.—Editorial in *San Francisco Chronicle*, January 10, 1945.

### Health Insurance Bill Pressed By Warren

By R. W. Jimerson

Examiner Bureau, Sacramento, Jan. 10.—The assembly today voted unanimously to continue the \$50 monthly old age pension on a permanent basis and at the same time moved to investigate pension advocates and promoters with particular emphasis on the collection of funds.

Meanwhile, Governor Earl Warren declared that passage of a compulsory health insurance bill is "one of the main orders of business" in his office, and that he knows of "no reason why the legislature cannot arrive at a sound decision this session." . . . Meanwhile, Governor Warren left no doubt that he will fight vigorously for enactment of a health insurance program, and similarly made it clear that he will urge adoption of a rounded plan, without compromising basic principles.

He said the compulsory health insurance bill is now being drafted in his office, that he and his secretaries worked on it until after midnight this morning, and that the mechanics of prepaid medical care are "very complicated."

### Deduction Program

The Governor wants health insurance financed by pay roll deductions applicable to both employers and employees, with no strings attached. Every member of the family will be covered if the legislature takes the Warren program.

The house of delegates of the California Medical Association has declined to endorse the Governor's proposal. Many Republican legislators do not view compulsory health insurance with favor, either, but they are reluctant, at the same time, to oppose Warren, particularly as Democratic members are gleefully espousing the program. Also watching results is the CIO, which plans to present its own health program as an initiative measure at the 1946 general election, if Warren's bill fails to carry at this session.

Whatever the fate of his bill, Warren indicated he will not condone any stalling for time.

He said he could not tell who would handle the various administration bills until the committees are appointed, but added that he planned to confer with committee heads of each house as soon as appointments are made.—*San Francisco Examiner*, January 11.

### Press Release from California Medical Association

San Francisco, January 11, 1945.—California's doctors are ready to give Governor Warren any requested assistance in writing his proposed health insurance bill despite the fact that the doctors have officially gone on record as being opposed to the compulsory system which the Governor has announced.

That statement was made here today by Dr. Philip K. Gilman, chairman of the Council and president-elect of the California Medical Association.

"The Governor has not requested the California Medical Association to give him any help on his proposed bill," Dr. Gilman said, "but the Association is ready and willing to supply any technical details which

the Governor may request. Through our experience of the past six years with California Physicians' Service we have accumulated a mass of actuarial data which we will be glad to lay in the proper hands upon request. It is doubtful if material of such value could be assembled from any other source in the country.

"If the Governor wants this material, all he need do is ask for it. However, this does not mean that the California Medical Association is acting as co-sponsor for any plan which might be evolved from the use of such facts and figures as we may be able to furnish. The House of Delegates of the California Medical Association has gone on record officially as opposing any compulsory health insurance plan which has so far been presented to it, including the outline of Governor Warren's plan as announced in the press and as given directly by the Governor to the Council of the Association."

Dr. Gilman detailed some of the reasons why the medical association is against a compulsory health insurance plan at this time, laying particular stress on the manpower shortage and the impracticability of setting up such a system under wartime conditions.

"The Californian Medical Association went on record in 1938," he said, "as favoring a system of health insurance. That was when California Physicians' Service was organized. This service has only recently emerged from the statistical study period encountered at the outset and has gained the knowledge of how a widespread health insurance plan can be operated with satisfaction to both the patient and the doctor.

"If we now attempt to extend such practices to a compulsory health insurance system and saddle the doctors and the patients with a new set of regulations and further payroll deductions, we are facing an immediate breakdown of the entire system of medical care in California.

"In the first place, there is grave doubt that sufficient manpower could be found to staff the administrative offices necessary in a Statewide compulsory plan. In the second place—and this is where the doctors are directly concerned—there are certainly not enough doctors in California to handle the additional medical work which would be thrown upon their shoulders if such a plan were instituted.

"The doctors of California and of all other states are working at top speed today. The death rate among the physicians is climbing because of overwork, long hours and the attempt to care for all cases which really demand attention.

"Now the Federal Government is talking about drafting nurses and thus cutting off one of the mainstays of the doctors' offices. The burden in doctors' offices is already too great and any compulsory health insurance plan which is added on the top of the present medical structure can only bring a collapse.

"The California Medical Association has offered an alternate solution for immediate adoption. It has suggested that workers who are out of employment because of illness be granted unemployment benefits from present unemployment funds. Such benefits would help to ease the burdens of loss of income, and medical and hospital expenses for the employed person.

"At the same time, the California Medical Association has gone on record as recognizing that a problem exists in the distribution of medical care and has suggested that a joint committee of physicians, dentists, labor, management, government, agriculture, hospitals and others be established immediately for the purpose of conferring on a complete and comprehensive plan to cover the entire problem of health service in California. Invitations to all groups concerned will be issued by the California

Medical Association within the next few days for a joint meeting to be held, if possible, within the next two weeks."

### Aid in Health Plan Offered

#### *Doctors Ready to Help Write Insurance Bill*

The doctors of California are ready to give Governor Warren "any requested assistance" in writing his proposed health insurance bill despite the fact that the doctors have officially gone on record as opposed to the plan, it was announced here yesterday by Dr. Philip K. Gilman, president-elect of the California Medical Association.

Pointing out that "the Governor has not requested the association to give him help on his proposed bill," Dr. Gilman said the association nevertheless "is ready and willing to supply any technical details which the Governor may request."

Doctor Gilman offered "a mass of actuarial data" accumulated "through our experience of the past six years with California Physicians' Service." The Governor can have the material, Doctor Gilman said, although "this does not mean that the association is acting as co-sponsor for any plan which might be evolved from the use of such facts and figures as we may be able to furnish."

Doctor Gilman detailed reasons why the association is against a compulsory insurance plan at this time, laying particular stress on the manpower shortage and "the impracticability of setting up such a system under wartime conditions."—*San Francisco Examiner*, January 12.

### Doctors Can Help

It is encouraging to note the gesture of the California Medical Association in offering to assist Governor Warren and the Legislature in their study of the subject of compulsory health insurance. The medical profession can supply much information of value in connection with this matter.

Also, the Association's plan to hold a joint meeting of doctors, labor representatives, business management leaders and Government officials, including legislators, for thorough discussion of the subject should prove helpful.

In view of the recent recommendations of the Association's committee against compulsory health insurance, we assume the purpose sought to be achieved is education of these groups to oppose the plan. That is a perfectly legitimate way to proceed.

However, we wonder if the doctors may not by the same process, receive some education themselves that will open their eyes to the necessity and, perhaps, the wisdom of setting up a Statewide plan of medical care that will benefit everybody.

We hope their minds are open to this conviction, as they no doubt hope the minds of the people generally are to their point of view.

In his message Governor Warren said we have had plenty of studies and surveys, now the time has come for action. When last the issue became critical the medical profession met it by organizing the California Physicians' Service. But that plan has scarcely scratched the surface of the need. If, then, the profession is determined to defeat the governor's plan, it must come forward with something better. Failing that, we believe the doctors should truly cooperate to help work out a State plan that will be beneficial to the people and at the same time fair to the medical profession.

By its offer to participate in the Legislature's study, the California Medical Association has started in the right direction.—*Editorial in San Francisco News*, January 13, 1945.

## Governor Warren Bares Details of Prepaid Medical Care Plan

*Bills to Be Introduced Friday; Governor Admits Many Questions Unanswered*

Examiner Bureau, Sacramento, Jan. 14.—First specific details of the proposal which is expected to develop the hottest fight of the 1945 session—prepaid medical care or "compulsory insurance"—were revealed today by Governor Earl Warren in advance of the anticipated introduction of the bill itself not later than Friday.

The Governor repeatedly has declared that he ranks his recommendation for prepaid medical care among the major issues in his 1945 program. He said the bill would be introduced simultaneously in both houses.

Assemblyman Albert C. Wollenberg, Administration leader and chairman of the Ways and Means Committee, will handle it in the lower house, and Senator Byrl Salsman in the Senate.

### Highlights Outlined

Highlights of the program as outlined by Warren, based on the assumption that the legislature will accept the bill as drawn, include:

1. The system will go into effect at the beginning of 1947, with payroll deductions beginning six months earlier to build up a fund.
2. Payroll deductions will be 1½ per cent, taken from both employer and employee, against a maximum of \$4,000 salary yearly. (Unemployment insurance taxes are assessed against the first \$3,000.)
3. Contributions are expected to be deductible from both Federal and State income taxes.
4. Everyone covered by unemployment insurance will go into the prepaid medical care system automatically, and those not covered—the self-employed and farm laborers, for example—will be encouraged to come in on a voluntary basis. Everyone in the family of the worker will be entitled to medical care, not merely the member from whose check the contribution is taken.
5. Service will be on a "fixed fee" basis—so much per call at home or office, so much for various types of treatment, and so on through minor and major operations.
6. Hospital charges will be included in the benefits under the system.
7. Industries having their own private medical care or hospitalization programs, either with or without employee contributions, will be given an opportunity to come in to the State system.

Repeatedly in his long conference with newsmen today, Warren asserted that there is no intent to regiment the medical profession, or force the public to accept a single type of service.

### Ceiling on Charges

While the fee system will be used, he said, rather than the capitation system which gives the doctor a fixed amount per month or year for each patient cared for, the "ceiling" on charges applies only when the service is paid for from the State fund.

In other words, wealthy persons could pay higher fees if they so desired, but no part of the fee, in such cases, could come from State funds.

"If a man is in the fund," Warren said, "and has so much money he does not want the same standard of care the average citizen gets, he can pay the doctor anything he pleases but he can make no claim in such case against the fund."

"The doctor cannot charge him \$50 for a service carrying a \$20 scheduled fee, collecting \$20 from the fund and the remaining \$30 from the patient. We don't want to mix the two."

"There may be some doctors who won't want to come into the system, who will want to continue treating only

wealthy patients. That is perfectly all right with us. The same thing applies to certain hospitals which may prefer to remain outside the system, providing for wealthy patients."

### Doctor's Choice

"The point we make is that when a doctor is operating under the State fund, he may collect only the fee provided in the fund. Otherwise there would be a tendency to drive standards down—to make people believe that State service is not adequate, and that by paying a little more, they could be better cared for."

Doctors need not "elect," however, to practice under the State system. They may have patients whose bills are defrayed by the fund, and other patients who prefer to pay heavier charges in the hope of getting superior medical service.

"We don't want to prevent doctors from having any type of practice they are entitled to," Warren said.

The "fee" system was preferred, Warren said, because of its greater efficiency in bringing the work of specialists into the system. The capitation system, however, will be proposed in amendments to be submitted by those favoring that plan.

The Governor explained that "we must have the fee system anyhow, for specialists, and we also need it to incorporate the services of dentists in the plan. Some services such as oral surgery are common to both professions."

### Limited Dentistry

"While tooth pulling and more difficult types of oral surgery practiced by dentists will be included in the program," Warren indicated that tooth filling and denture making will not.

Questions too numerous to recount remain to be settled, Warren conceded. Many of them will be dumped into the lap of the administrative agency set up to direct the State's venture into compulsory health insurance. Others cannot be settled until experience provides the answer.

Among these questions are: Shall there be a waiting period before a migrant from outside California becomes eligible?

Shall a contributor to the fund, who has never drawn upon it for medical care, receive his money back when he leaves the State?

Shall the State make special provisions for the immediate admission of former servicemen and women into the system?

What can be done to prevent thousands of individuals from demanding immediate relief for their accumulated, long untreated ills as soon as the State system takes effect, which has been a major problem faced by many private and semipublic systems?

Warren ended a two hour "seminar" for newsmen by expressing the conviction that employers will benefit financially by the system—that they will reap rewards in increased efficiency and production when employees are healthy, and are relieved of worry over the health of their families.—R. W. Jimerson, in San Francisco Examiner, Monday, January 15, 1945.

### California Health Insurance Program

*Payments Under Warren's Plan Will Start in 1946, Benefits to Begin in 1947*

Sacramento, Jan. 14.—Collections from employers and employees and others to finance Governor Warren's pro-

posed health insurance program will begin in 1946 and payment of benefits will commence January 1, 1947.

The Governor announced these facts today in making public for the first time some of the important provisions tentatively agreed upon for inclusion in the Warren "pre-paid medical under a compulsory health insurance system" bill to be presented to the legislature this week.

The program will include medical, dental and hospital care to those contributing to the system and to members of their families.

#### Bill to Be Introduced

"We hope to introduce our bill in both houses of the Legislature the latter part of the week," said the Governor.

Senator Byrl R. Salsman, Palo Alto, and Assemblyman Albert C. Wollenberg, San Francisco, will handle the legislation in their respective Houses.

Governor Warren said many important points are yet to be settled in connection with the final draft of his bill.

The following broad principles have been agreed upon:

1. Cost of health insurance will be met by a payroll contribution of 1½ per cent by both employer and employee or 3 per cent by a self-employer or other person who wishes to join the system.

2. Inclusion of all persons currently under unemployment insurance but with the tax applying only on the first \$4,000 of annual income.

3. Payment of doctors and dentists on a fee basis with fees varying for different types of service.

4. Permitting continuation of existing voluntary health insurance programs where they meet State standards, but requiring payroll deductions for the State fund, regardless of any payments to the private fund.

5. Complete freedom of choice between patient and doctor.

6. Fixing of a "ceiling" only on medical fees that are paid out of the State fund.

7. Contributors to the State system who desired to pay doctors higher fees than those allowed by the State program would not be entitled to receive any portion of those higher fees from the fund.

#### No Side Agreements

8. Doctors would not be permitted to make "side agreements" for extra fees than those allowed by the State and continue to be eligible for State payments because of the danger medical service might deteriorate for those not paying the extra sums.

9. No exemptions from payroll contributions would be granted those wishing to be treated by a doctor not participating in the system.

10. Hospital charges will be included with a maximum limitation of time to be spent in a hospital.

11. Doctors electing not to participate in the State system could remain out.

12. Collections and payments to and from the health insurance fund to be handled by existing State agencies.

13. Establishment of an advisory governing board to determine policy and creation of a medical director to act as executive officer in administration of the health program.

The Governor said every survey he had seen "has indicated the majority of the medical men who are in the Armed Forces favor some kind of group medicine."

"I have preferred the fee system to the capitation plan," said the Governor.

Under the capitation plan doctors would receive a uniform payment of fees payable per capita for each of their patients.

"The capitation system," said the Governor, "would militate against inclusion of the dentists and medical specialists in the system."

Warren said he believed that where a person has been contributing to the health insurance system and leaves California before getting any benefits, he should be allowed a return of at least a part of his contributions.

#### Tax Deductions

Payments to the health insurance system would be allowable deductions against both Federal and State income taxes, the Governor said.

One of the "enormous problems which will be faced at first," said Warren, "will be the treatment of 'hypochondriacs.'" He said medical men would have to deal with the problem themselves.

Chiselers, charlatans and similar persons might turn up in both the ranks of the doctors and the patients, Warren declared. But he believed the medical profession would do its own "policing" just as it does now.

Both houses of the Legislature resume sessions today following the week end recess.—Earl C. Behrens, Political Editor, in *San Francisco Chronicle*, Monday, January 15, 1945.

#### Governor Warren's Bill for Medical Care Periled

##### *Competing Measures Threaten the Governor's Medical Care Bill*

Sacramento, Jan. 15.—Governor Warren's proposed State compulsory health insurance program is in danger of being shunted off to an interim committee for protracted study . . . and there may be no action upon it at this session.

The Governor yesterday announced his bill, which will be introduced in the Legislature later this week, provides for collections from employers and employees during 1946 and commencement of benefit payments January 1, 1947.

One thing is certain: There will be plenty of controversy over health insurance. The Governor has said he believes that now is the time for action.

At present, it appears there will be a number of health insurance bills in addition to that to be introduced by Assemblyman Albert C. Wollenberg, San Francisco, and Senator Byrl R. Salsman, Palo Alto, in behalf of Governor Warren. The CIO is preparing a bill, and the California Medical Association, according to Ben Read, its legislative representative, will have a measure before the session ends.

With the prospect of competing legislation, the way will be made easier to bottle up the Governor's proposal by urging further study and sending all of the proposals to another committee.

In the Senate, Senator Jesse M. Mayo, Angels Camp, will head an 11-member Welfare Committee, to which the health bill will be sent for its first hearing. Mayo has an open mind on the subject, but the make-up of the committee indicates the other 10 members may have some pretty fixed opinions on the proposal.

In the Assembly, Speaker Charles W. Lyon will send the Governor's bill to the Public Health Committee. Fred Kraft, a San Diego druggist, is chairman of the committee and has expressed himself as opposed to any compulsory health insurance bill.

#### Lower House Prospects

The make-up of the Lower House Committee indicates some of the members there also may be looking for an out so as to keep the Governor's program from being enacted. To call for further study would be one way of accomplishing this.

The California Medical Association has definitely declared itself to be against any "system of complete compulsion" and will offer legislation providing for further expansion of voluntary physicians' service organizations.

The Association is expected to seek legislation providing for the payment of unemployment compensation during periods when employees are out of work because of illness and to provide for the reduction of pay roll taxes for unemployment purposes in those cases where employees are already enrolled in voluntary health programs.

The so-called "liberals," however, who have been shouting for progressive legislation will find themselves hard put to vote against the Governor's bill if it ever gets to the floor of the Legislature.

To clear the decks for early study of the Governor's 1945-47 State budget, which will be presented this week, Chairman Wollenberg of the Assembly Ways and Means Committee today organized his committee; 14 subcommittees made up of the 25 members of Ways and Means will devote themselves to the budget. The subcommittees include general administration, agriculture, corrections, education, the University of California, fiscal affairs, industrial relations, institutions, military affairs, motor vehicles, natural resources, social welfare, Department of Justice and water resources. . . .

Additional items recommended by Governor Warren were included in bills introduced today. Assemblyman John C. Lyons, Los Angeles, presented bills putting domestic help and agricultural workers under unemployment insurance and also making employers of one employee come under the unemployment insurance system. At present, an employer is excluded unless he employs four or more persons.

The two bills were not presented as administration measures, however.

(The Associated Press estimated that the two measures would expand the unemployment act to bring nearly 400,000 additional workers under its provisions. The State Employment Department said that the measure would affect 150,000 workers for employers hiring less than four people; 75,000 domestic and 169,000 agricultural workers. If those self-employed in agriculture were included an additional 130,000 would be affected. In June of last year 2,204,000 were subject to the act.) . . . —Earl C. Behrens, Political Editor the Chronicle, in *San Francisco Chronicle*, January 16, 1945.

### California Health Insurance

#### *Six Bills to Go Before Legislature; Doctors, Labor Back State Program*

Sacramento, Jan. 17.—The Legislature will have at least six health insurance bills before it at the current session.

In addition to Governor Warren's program to be embodied in a bill expected to be ready for introduction next week, there will be two measures sponsored by the California Farm Bureau Federation, one by the Democratic majority bloc in the Assembly, another by the CIO, a bill by the California Medical Association and two or three others.

Senator George J. Hatfield, Merced county, will author the two bills of the Farm Bureau Federation.

Von T. Ellsworth, representing the federation, states there is no conflict between the Farm Bureau plan and Governor Warren's since farmers are not now covered by unemployment insurance.

The first of the Hatfield measures provide formation of health service associations by doctors and laymen. It would be a voluntary rather than a compulsory service except that all organizations providing medical care on a periodic payment basis would have to come under its provisions.

### County Hospitals

The second bill relates to the use of county hospitals. It would authorize boards of supervisors to adopt a policy of admitting any and all county residents to be hospitalized in county hospitals and to charge for such services on the basis of the patient's ability to pay.

The Democrats are waiting to see what Governor Warren's bill covers before bringing in their measure. One proposal made by the Democrats is that the cost of compulsory health insurance be split among the employer, employee and the State. The Governor's program calls for a 1½ per cent pay roll contribution from employer and employee.

The Democratic bill may also contain the capitation system of payment whereby a doctor receives so much per capita for the care of each person who is his patient. The Governor favors a fixed fee payment plan.

### CIO Favors System

The CIO bill will propose the capitation system of payments rather than the fee system.

Senator Fred Weybret, Monterey county, will father a bill permitting formation of hospital care districts.

The California Medical Association bill will not be presented for several days.

Meantime, Dr. Ernest Sloman of the California Dental Association conferred here today with Assemblyman Albert C. Wollenberg, San Francisco, who will handle the Governor's health bill in the lower house. Sloman favors the general program outlined by the Governor. . . .

—Earl C. Berens in *San Francisco Chronicle*, January 17, 1945.

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## COUNTY SOCIETIES†

### CHANGES IN MEMBERSHIP

#### New Members (17)

##### Contra Costa County (7)

Bernstein, S. L., *Pittsburg*  
 Gray, A. Bernard, *Richmond*  
 Loewenstein, Hans G., *Pittsburg*  
 Mills, Martin, *Richmond*  
 Moran, James A., *Richmond*  
 Rea, Stanley L., *Richmond*  
 Riklin, Henry H., *Richmond*

##### Riverside County (1)

Eilers, Paul G., *Riverside*

##### San Francisco County (6)

Bartlett, Alexander G., *San Francisco*  
 Buerger, Walter Richard, *San Francisco*  
 Downing, George C., *Carlisle Barracks, Pa.*  
 Durfee, Raphael Burke, *San Francisco*  
 Langley, Ivan Ira, *San Francisco*  
 Modley, Betty D., *San Francisco*

##### Santa Barbara County (2)

Gibb, William Blake, *Santa Barbara*  
 Day, Jane M., *Santa Barbara*

##### Santa Clara County (1)

Ehrhart, John D., Jr., *San Jose*

#### Transfers (1)

Behneman, Harold M. F., from San Francisco County to Riverside County

Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

**Smith, Ralph Merle.** Died at Glendale, November 28, 1944, age 57. Graduate of the College of Medical Evangelists, Loma Linda, 1916. Licensed in California in 1916. Doctor Smith was a member of the Riverside County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

**Turner, Jesse Harold.** Died at La Canada, November 20, 1944, age 48. Graduate of Loyola University School of Medicine, Chicago, 1927. Licensed in California in 1927. Doctor Turner was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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War Housing Program.....	26,336	15,560
Total Membership .....	79,356	107,571

On an over-all basis, the significant event of California Physicians' Service appearing before the Pepper Committee on Wartime Health and Education will be of interest. A report of this is in the October issue of CALIFORNIA AND WESTERN MEDICINE, on page 207. It will suffice to state here that C.P.S. was the only medical service plan in the nation which was invited to appear. It is also to be noted that a Pepper Field Investigating Committee will probably come to the West Coast during the coming months for further detailed study of C.P.S.

In general, C.P.S. is beginning to expand rapidly, as evidenced by the rate of acquisition during the past three months:

August .....	10,012 persons
September .....	7,127 persons
October .....	23,079 persons
Total .....	40,218 persons

C.P.S. continues to pay its \$2.25 unit value, but has drawn heavily from its reserve, due to the high incidence of surgery during summer months, in order to maintain this. At the last meeting of the Board of Trustees, held November 19th, Mr. Ralph R. Nelson, the actuary who

†Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M.D., Medical Director.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

## In Memoriam

**Hill, Reuben Chandler.** Died at Coalinga, November 20, 1944, age 69. Graduate of the University of California Medical School, Berkeley-San Francisco, 1901. Licensed in California in 1901. Doctor Hill was a member of the Tulare County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

**McAulay, Martin.** Died at Monterey, November 3, 1944, age 69. Graduate of the Hahnemann Medical College of the Pacific, San Francisco, 1904. Licensed in California in 1904. Doctor McAulay was a member of the Monterey County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

**Orella, Fermin Ralph.** Died at San Francisco, December 4, 1944, age 76. Graduate of the Cooper Medical College, San Francisco, 1892. Licensed in California in 1893. Doctor Orella was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

**Sellery, Albert Clifton.** Died at Long Beach, November 24, 1944, age 69. Graduate of McGill University Faculty of Medicine, Montreal, 1904. Licensed in California in 1906. Doctor Sellery was a member of the

†For roster of officers of component county medical societies, see page 4 in front advertising section.

has been retained by C.P.S. since its inception, reported on the first solid year of experience under C.P.S.'s new *Surgical Contract*. This report revealed that the rate of the present use of service and the dues for beneficiary membership would not develop the goal of the \$2.50 unit value. Consequently, it was recommended that our rates be increased to meet this. The Board of Trustees unanimously approved this recommendation, as contained in the following resolution:

WHEREAS, For the past year, and since the readjustment of medical and surgical benefits, the Board of Trustees of C.P.S. has been concerned with the inability of its present dues structure to produce sufficient income to meet the necessary costs of operation and services; and

WHEREAS, The Board has withheld action for approximately one year in order to permit its actuary, Mr. Ralph R. Nelson, to complete a study of experience; and

WHEREAS, Mr. Nelson has now completed such comparative study and has reported that either (a) dues must be raised, or (b) service to members curtailed; and

WHEREAS, After extended discussion the Board rejects any reduction of service as incompatible with adequate medical care, and therefore must raise dues of beneficiary members in an amount necessary to produce sufficient income; now, therefore be it

*Resolved*, Beneficiary membership dues are hereby revised as follows:

Surgical Coverage: \$.80 per month per man  
1.20 per month per woman  
2.00 per month for two-person family  
3.00 per month for three or more person family  
Medical Rider: .90 per month

And be it further

*Resolved*, That, with respect to new members, said revised dues shall be effective from and after December 1st, 1944, and that with respect to existing members, dues be revised as soon as possible under present contractual commitments; and be it further

*Resolved*, That the officers and administrative staff are hereby instructed to notify all professional and beneficiary members and all other interested persons of the terms of this resolution, and carry same into effect.

Significant administrative changes have occurred.

C.P.S. has created the position of an *Assistant Director*, who will have charge of the entire Southern Area, and it has also changed the operations of the Medical Department in the South with the employment of a full-time physician.

A new department has been created within C.P.S., which is beginning on an experimental basis, and which has been temporarily designated the "*Department of Professional Relations*." The function of this department is to contact physicians in their offices, and also talk with their nurses. Routine calls are being made upon all physicians, and definite gains have been made in the understanding of the C.P.S. program.

The attitude of the medical profession toward C.P.S. is evidenced by a noticeable diminution in the number of complaints from beneficiary members. This is evidence that physicians are rendering better service.

Most of the County Medical Societies have accepted the proposal from the C.M.A. that all new members of the County Society be acquainted with the principles of C.P.S., so that they may decide whether or not to become professional members. Since the May meeting in 1943, over 240 doctors have become professional members, with the activities of increase more evident during recent months, 63 new members having joined in October—the highest month since the organization of C.P.S.

Through the kindness of certain key physicians in several communities, the administrative staff has been offered the opportunity to sit down with groups of physicians, including nonbelievers, those without any particular concern and proponents of C.P.S. These discussions have been invaluable in acquainting these men with the history, problems and philosophies underlying California Physicians' Service.

With reference to the *recent action by a group of Alameda physicians* enjoining physicians in that area to resign from C.P.S., there have been gains and losses, but the net has been a loss of only seven physicians, leaving a total of 289 professional members still remaining, which is sufficient for us to give adequate service. . . .

T. HENSHAW KELLY, M.D.,  
Secretary.

\* \* \*

(COPY)

#### CALIFORNIA PHYSICIANS' SERVICE A Nonprofit Corporation

Dear Doctor:

The California Medical Association, County Medical Associations, and Professional Members of California Physicians' Service have united their efforts to assist C.P.S. in its Professional Membership Drive.

We need the support of every physician if we are to meet successfully our mutual problems.

If a physician in your community is not a member of C.P.S. will you urge him to join now? Please write us if you should want an application form and other descriptive material.

Thank you for your coöperation in this new professional membership drive.

Very sincerely,  
A. E. LARSEN, M.D.,  
Executive Medical Director.

\* \* \*

#### C.P.S. Beneficiary Members (Report for January "C. & W. M.")

	October 1943	October 1944
Commercial Program.....	51,350	93,000
Rural Health Program.....	2,400	2,011
War Housing Program.....	20,867	15,200
Total Membership .....	74,617	110,211

As we note in the beneficiary membership statement, C.P.S. has now passed the 100,000 mark. This membership has been obtained in the face of a continuing labor turnover, which of course affects membership in C.P.S. Since C.P.S. deals only with groups, naturally the activities in those groups will affect C.P.S. accordingly.

There seems to be a growing interest on the part of industry and labor, and with the renewed support of the medical profession, our representatives are having less and less difficulty in obtaining large groups in old-line industries which, while expanded during wartime, will still be sizeable postwar organizations.

The recent pre-optimistic reaction to the war situation has not only affected our Commercial Program, but has had a much greater effect on our War Housing Program, which was to be expected. Migration from the temporary War Housing Project areas increased alarmingly during the latter months of the year, and in some areas—in particular, Vallejo—has seriously affected the continuity of the program.

At this writing, very significant events are occurring in the ranks of the medical profession, and there is considerable discussion about the place of C.P.S. in the future of medicine in the State of California. As developments occur, we shall keep the profession informed through this channel.

## CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

### War-Time Graduate Medical Meetings in California

The War-Time Graduate Medical Meeting Committee for Zone 24, which comprises the Southern Counties of California, has initiated a full-scale Graduate Medical Meeting program. The War-Time Graduate Medical Meetings are sponsored by the American Medical Association, the American College of Physicians and the American College of Surgeons with the authorization of Surgeons General Norman T. Kirk, Ross T. McIntire and Thomas Parran.

The committee is composed of Capt. Harry P. Scherick (MC)USNR, of the U. S. Naval Hospital, Oceanside, California, Wayland A. Morrison, M.D. of Los Angeles, James Churchill, M. D. of San Diego, and Lt. Comdr. Geo. C. Griffith, (MC)USNR, Chairman, of the U. S. Naval Hospital, Corona, California.

Through the splendid cooperation of Capt. Jno. B. Kaufman, (MC)USN, District Medical Officer of the 11th U. S. Naval District, Capt. H. L. Jensen, (MC)USN, Medical Officer in Charge of the U. S. Naval Hospital, Corona, Capt. W. H. Leake, (MC)USNR, Chief of Medicine of the U. S. Naval Hospital, Corona, and Col. Verne Mason, MC, Medical Consultant, Office of the Service Command Surgeon, medical programs at bi-monthly intervals are presented in each of the following installations:

A.S.F. Regional Hospital, Camp Haan, Riverside  
A.S.F. Regional Hospital, Santa Ana Air Base, Santa Ana  
Birmingham General Hospital, Van Nuys  
Camp Cooke, Lompoc, California  
March Field, Riverside  
U. S. Naval Hospital, Corona  
U. S. Naval Hospital, Long Beach  
U. S. Naval Hospital, Oceanside  
Torrey General Hospital, Palm Springs.

Programs are planned along general medical and surgical lines. Programs in the specialties are scheduled at appropriately spaced intervals.

Faculty for this teaching program has been selected after careful consultation with the Commanding Officers of each of the Army and Navy medical installations, and especially through the help and advice of Dean B. O. Raulston of the Medical School of the University of Southern California and President W. E. McPherson of the School of Medical Evangelists.

Composing the medical staffs of the service installations in this district are many of the leading University teachers of this country.

Captain Morton Willcutts (MC)USN, Commanding Officer of the U. S. Naval Hospital, San Diego, is presenting to the doctors of San Diego and environs a splendid medical program each Thursday afternoon.

The civilian physicians in the neighborhood of each of the Army and Navy medical installations have been invited to participate in these programs. Announcements will appear at regular intervals giving subjects and speakers.

This educational program is being conducted for civilian as well as service doctors and we wish to keep them regularly posted of the lectures.

The central office of this committee is located at the U. S. Naval Hospital, Corona, and communications addressed to the committee should be sent to this address, directed to the Chairman, Lt. Comdr. Geo. C. Griffith, (MC)USNR.

### War Death Toll of Doctors 326

Chicago, Jan. 11.—(U.P.)—A total of 183 physicians died in military service during 1944, the *Journal of the American Medical Association* reported today, bringing the total to 326 since the war started.—*San Francisco Chronicle*, January 12.

### U. S. Casualties Reach 646,380 Exclusive of West Front Loss

Washington, Jan. 11.—(I.N.S.)—Secretary of War Stimson today promised to make public casualty figures reflecting losses in the German breakthrough in Belgium and France at his news conference next Thursday.

The past week, which he said reflected casualties early in December, showed an increase of 7,999 from the previous report. They represent figures compiled through December 29 but, Stimson explained, they reflect actual casualties of a period of two or three weeks earlier.

Cumulative figures since the beginning of the war now are 106,952 killed, 333,849 wounded, 64,283 missing, 59,267 prisoners of war, making a total of 564,351.

The War Department totals, added to the figures of the Navy, Marine Corps and Coast Guard, make a grand total of 646,370 casualties of all types.

Total naval casualties of today are 41,838, divided as follows: Dead 20,683, wounded 10,312, missing 8,307, prisoners 2,536.

Marine casualties total 39,328 as follows: Dead 10,186, wounded 26,292, missing 907, prisoners 1,943.

Coast Guard, total 862; dead 572, wounded 194, missing 97, prisoners none.—*San Francisco Call Bulletin*, January 11.

## COMMITTEE ON POSTGRADUATE ACTIVITIES†

### Reginald Knight Smith Lecture

Mount Zion Hospital, San Francisco

Mount Zion Hospital, San Francisco, is inaugurating an annual lecture to be known as the *Reginald Knight Smith Lecture*, in memory of Dr. Reginald Knight Smith who served as Chief of the Division of Obstetrics of Mount Zion Hospital from 1909 to 1937, and in recognition of his outstanding medical service to the community.

Every year a prominent speaker of national medical repute will be invited to be the guest speaker on a subject of interest to the general medical profession preferably concerned with the newer developments in medicine. This year Dr. Philip Levine, formerly associated with the Rockefeller Institute and now Director of the Biological Division of the Ortho Research Foundation, Linden, New Jersey, has been invited to give the first lecture January 11, 1945, on the subject of Rh Factor, and Its Clinical Significance. Dr. Levine first published his work on this blood entity known as the Rh Factor in 1939 and later described the underlying causes of fatal hemolytic jaundice (erythroblastosis fetalis). It is known that a number of diseases, including many of the toxemias of pregnancy and repeated abortions and miscarriages, are due to the absence of the Rh Factor in the blood of certain women and its presence in their husbands and offspring. Children of an Rh positive father and an Rh negative mother may not only develop severe or fatal hemolytic jaundice (erythroblastosis fetalis), but may become mentally retarded because of injury to nuclei of their brains during gestation.

Dr. Levine received the Gold Medal award for his exhibition on Erythroblastosis Fetalis presented by the American Society of Clinical Pathologists in 1942. In

the same year the Mead Johnson Award was also presented to Dr. Levine for this original contribution. In 1935 Dr. Levine wrote the Wisconsin Law and in 1939 the New Jersey Law which authorized the courts in these states to order blood grouping tests in cases of disputed paternity. He has written numerous papers dealing with legislation on blood tests for non-paternity, individual differences of human and animal blood, and prevention of blood typing transfusion accidents. He has been on the faculty of the University of Wisconsin School of Medicine and a member of the staff of the Newark Beth Israel Hospital. He is a member of many academic and honorary societies, including Sigma Xi, American Society of Clinical Pathologists, Harvey Society, and the Society of Experimental Biology and Medicine.

## COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

### Figures on Army Nursing Problem as Given by Dorothy Thompson in "San Francisco Chronicle"

The proposal to draft nurses has led this column to make a mathematical investigation. It furnishes startling testimony to the devotion and patriotism of the nursing profession, and raises the question of whether this matter cannot be better settled on a volunteer basis than by compulsion. Here are the facts:

The total of active trained American nurses is, in round numbers, 265,000.

Of these it is estimated 25 per cent are over the age of 45 and ineligible for army service.

That reduces the figure to about 199,000.

Army nurses may have no dependents. Of all women's professions, nurses have the highest marrying average. In 1943, when the last full survey was made, 40 per cent were married.

There are no figures available to show how many have children, but it is conservative to estimate there are 49,000.

If this is correct, then there are, altogether, only 150,000 trained nurses eligible for the services.

And 75,000 nurses have already volunteered for the armed forces, half the eligible nursing profession of the United States!

I submit that in no other profession of our population is there so high an average of the volunteer spirit.

Forty-three per cent of the 75,000 volunteers were rejected or released by the services for various reasons, most of them involving physical unfitness. The services demand women able to go anywhere, under any circumstances, with an extraordinary degree of physical, mental, and emotional superiority.

The procurement assignment service of the Manpower Board has found only 41,000 who can be considered eligible. None of these have gone through Army tests. Presuming they are no better nor worse than the 75,000 free-willers, the 41,000 would boil down to 26,800.

And what is actually needed is 10,000 with replacements at the rate of 250 a month.

I submit the question of picking 10,000 out of 26,800 does not require a draft service for all women. It is a matter of individual investigation and public education...

Trained nurses are essential in operating rooms. But neither in the Army nor in civilian hospitals are they essential for emptying bedpans, making beds, giving baths, taking temperatures or administering prescribed medicines. One experienced trained nurse could train

corps of men or women for such services, and rapidly.

Desperately needed are large numbers of nurses' aides, both in civilian and military hospitals here at home. Of Army nurses 70 per cent are overseas. The other 30 per cent could be immediately available for overseas service if they could be replaced by overage nurses, useless for overseas work, but perfectly able to nurse the wounded who have been returned. That, however, means more nurses' aides in both civilian and military hospitals here.

But it is doubtful whether you can successfully draft women as nurses' aides. Most nurses' aides are doing part-time work, for which no draft could provide. Thousands of married women who could arrange their household and family duties to enable them to work two or three days a week in hospitals—and this is what most nurses' aides are doing—would have to be dropped if the demand were made for their full time.

To issue an order and draft women seems to be quick and efficient. But in this particular case I fear it will be the least efficient and longest way to solve the problem.

### "Res Ipsa Loquitur" In Malpractice

In a recent number of the *Bulletin* of the Los Angeles County Medical Association, appears the speech delivered by Marion P. Betty, Esq., at the meeting of the Los Angeles County Medical Association and Los Angeles Bar Association on Friday, September 29, 1944, at the Elks Club. Some excerpts follow:

Medical malpractice is the failure of a physician, undertaking the care and treatment of a patient, to possess or to exercise that reasonable and ordinary degree of learning, skill and judgment commonly possessed and exercised, by reputable physicians practicing in the same locality or in similar localities, in care of similar cases.

It also constitutes malpractice for the physician to fail to exercise his best judgment, at all times, in the care of his patient.

But the physician's best judgment must reach the required standard of that judgment commonly exercised by reputable physicians in similar cases in that or similar locality at that time. In other words, if the physician's best judgment fails to be equal to the common standard of reputable physicians, it is still malpractice, even though he exercises his best judgment.

The term, *res ipsa loquitur*, means, literally, "the thing itself speaks," but it is usually interpreted "the thing speaks for itself."

*Res ipsa loquitur* is a doctrine of the general law of negligence, but specifically it is a rule of evidence.

Originally the doctrine had no application to medical malpractice cases, but now it has been extended to such cases in most states. The trend is toward the extension of the doctrine in this field.

However, some states still do not recognize it.

In cases where the doctrine is applied it constitutes an exception to the general rule, which requires that the proof of a physician's negligence must be established by the testimony of qualified expert witnesses. . . .

Mercury is first referred to in the "*circa instans*" of Mattheus Platearius (1140).

## MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

### NEWS

#### Coming Meetings†

**California Medical Association.** Session will convene in Los Angeles. Dates of the seventy-fourth annual session, to be held in 1945: Sunday, Monday, May 6-7.

**American Medical Association.** The 1945 Session, previously scheduled for Philadelphia, will not be held. See J.A.M.A., January 20, 1945.

#### The Platform of the American Medical Association

The American Medical Association advocates:

1. The establishment of an agency of Federal Government under which shall be coordinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.
2. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.
3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.
4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.
5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.
6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.
7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.
8. Expansion of public health and medical services consistent with the American system of democracy.

(Note: For Interpretative comments, see J.A.M.A., June 24, 1944, pp. 574-576.)

#### Medical Broadcasts\*

**The Los Angeles County Medical Association:**

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays:

KFAC presents the Saturday programs at 10:15 a.m., under the title, "Your Doctor and You."

In December, KFAC will present these broadcasts on the following Saturdays: January 6, 13, 20, and 27.

The Saturday broadcasts of KFI are given at 9:45 a.m., under the title, "The Road to Health."

**"Doctors at War":**

Radio broadcasts of "Doctors at War" by the American Medical Association is on the air each Saturday at 1:30 p.m., Pacific War Time.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

\* County societies giving medical broadcasts are requested to send information as soon as arranged.

#### Pharmacological Items of Potential Interest to Clinicians\*:

1. **Philosophers Look to Scientists:** Columbia Univ. Press sponsors significant group of philosophical efforts attempting to apply implications of current knowledge to our faiths and beliefs: Ray Lepley's *Verifiability of Value* (N. Y., 1944, suggesting scientific basis for ethics); L. S. Eby's *The Quest for Moral Law* (ditto), and symposium edited by Y. H. Krikorian, *Naturalism and the Human Spirit* (ditto). But, alas, none refer to C. H. Waddington's *Science and Ethics: An Essay and a Discussion* (London, Unwin, 1942). The difficulties of western science in the philosophical development of the future are implied in the essays edited by C. A. Moore, *Philosophy East and West* (Princeton, 1944). The Princeton Press asks if you have discovered S. Kierkegaard (12 volumes available)? Seems to have been a rare Christian. A. E. Morgan offers fine appreciation of Edward Bellamy (1850-98), author of significant *Looking Backward*. (Boston, 1888), issued by Columbia Press (N. Y., 1944).

2. **Blood and Shock:** E. Mylon, C. W. Cashman and M. C. Winternitz summarize succinate and plasma therapy of tourniquet shock (*Am. J. Physiol.*, 142:299, 1944). I. H. Page describes cardio-vascular changes resulting from severe scalds (*Ibid.*, p. 366). J. E. Davis reports 3 oral doses 10 mgm./Kg. choline chloride daily reduces rbc's 30 per cent in normal dogs in 2-3 months and that liver or stomach orally corrects this hyperchromic anemia rapidly while atropine does so slowly (*Ibid.*, p. 402). A. E. Shaw & Co. emphasize hematocrit and plasma protein estimations in controlling infusions for shock therapy (*Med. J. Austral.*, 2:301, Sept. 16, 1944). Excellent symposium on blood: G. L. Taylor and R. R. Race and W. T. Morgan on blood groups and Rh; C. J. Britton on anemias; H. Scarborough on hemoglobinometry; and E. P. Sharpey-Shafer on dynamics of hemorrhage (*Brit. Med. Bull.*, 2:160-192, 1944).

3. **Choline enzymes:** J. F. Fulton and D. Nachmansohn & Co. suggest release of acetylcholine intracellularly depolarizes cell membrane rendering it permeable to all ions, thus generating action potential current to stimulate adjacent region; and show parallelism between choline esterase activity and voltage of action potential (*Science*, 97:569, 1943; 100:454, Nov. 17, 1944). F. Schutz shows high cholinergic activity is a factor in epilepsy (*Quart. J. Exp. Physiol.*, 33:35, 1944).

4. **Bacteriostatics and Antibiotics:** W. T. Salter gives full review of significance of antibiotics and bacteriostatics in blood and body fluids (*New Eng. J. Med.*, 231:651, Nov. 9, 1944). A. Winkler confirms local anesthetic inhibition of sulfonamide action (*Zentralb. bakt. parasit. infect.*, 151:106, 1944). D. G. Evans & Co. find p-methyl-sulfonyl-benzamidine HCl highly useful IM against *Cl. welchii* and other gas formers (*Lancet*, 2:523, Oct. 21, 1944). Skin sensitization to sulfonamides locally may be treated and prevented by low dosage orally, say B. C. Tate and L. Klorfajan (*Ibid.*, p. 553, Oct. 28, 1944). M. J. Romansky and G. E. Rittman's method of prolonging penicillin action by IM injection of peanut-oil and beeswax mixtures (*Science* 100:196,

\* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

Sept 1, 1944), is confirmed by G. W. Raiziss (*Ibid.*, p. 412, Nov. 3, 1944), in suggesting single injection daily. A. H. Free & Co. offer evidence of effective absorption of penicillin from oral administration (*Ibid.*, p. 431, Nov. 10, 1944). M. Trumper and A. M. Hutter apply ice bag to area of penicillin injection to delay absorption and thus to prolong action (*Ibid.*, p. 432). See special penicillin issue *Brit. J. Surg.* (32:109-224, July supplement, 1944), with fine color pictures in E. Culter's article, and H. Florey's principles of treatment.

5. *Looking to a Happier New Year:* Our own C. M. Pomerat and L. Anigstein are first to offer experimental check on Russian anti-reticular cytotoxic sera (*Science*: 100:456, Nov. 17, 1944). Our own G. A. Emerson notes limiting effects of privity (*J. Pharmacol.*, 82:42, 1944). R. M. Stecher continues keen studies on mechanism of inheritance of Heberden's Nodes (*J. Clin. Invest.*, 23:699, 1944). P. Cristol & Co. note relative rapidity of hydrolysis of monohalogenated acetic acids, confirming probability of negligible toxicity if used as food and beverage stabilizers (*Bull. Soc. chim.*, 11:58, 1944; *Univ. Calif. Publ. Pharmacol.*, 1:397, 1941). Great group of sex hormone reports form appropriate memorial to Edgar Allen (*Yale J. Biol. Med.*, 17:1-349, Oct., 1944). Note 2nd Ed. M. A. Pei's *Languages for War and Peace* (S. F. Vanni, 30 W. 12th, N. Y., 1944, \$5.00). Congratulations to Nobelates Dam, Doisy, Erlanger and Gasser! More next year!

**Beaumont Memorial Foundation Brochure.**—Organization of the Dr. William Beaumont Memorial Foundation is announced in a handsome brochure now available to members of the profession. The home of the foundation is at Prairie Du Chien, Wisconsin, where Dr. Beaumont carried on many of his history-making experiments. It is housed in a restoration of the old Fort Crawford Military Hospital.

The Foundation was organized as a memorial to the pioneer physiologist and as an American medical shrine. It is sponsored by a group of eminent medical men and community-minded Wisconsin citizens.

Officers and directors are: M. J. Dyrud, President; Dr. O. E. Satter, Vice President; Dr. T. F. Farrell, Treasurer; J. A. Dru'yor, Secretary; Cal Peters, Curator. Medical Advisors are: Dr. P. L. Scanlon, Dr. H. H. Kleinpell, Dr. J. J. Kane, Dr. C. A. Armstrong, Dr. E. H. Lechtenberg and Dr. E. M. Dessloch. Directors: Dr. W. D. Stoval, Chairman of the Board, Dr. O. E. Satter, Dr. T. F. Farrell, Mayor F. W. Clanton, Mr. P. H. Schmidt, F. A. Otto and M. J. Dyrud.

Advisory Board: Dr. Walter J. Meek, Chairman. Members: Dr. Arno B. Luckhardt, Dr. Walter B. Cannon, Prof. Ben Elliott and Dr. Edward P. Alexander.

The announcement brochure gives an interesting history of Beaumont, the New England boy whose backwoods research and observations laid the ground work of modern physiological science. It carries many excerpts from Dr. Beaumont's diaries as well as his famous "51 Inferences."

Medical men may secure a copy of the booklet by writing the Dr. William Beaumont Memorial Foundation, Prairie Du Chien, Wisconsin.

**NBC Radio Broadcasts.**—Beginning January 6 and continuing through June 30, 1945, the American Medical Association and the National Broadcasting Company will present the twelfth consecutive season of nationwide network health broadcasts.

The title of the series for 1945 will be *Doctors Look Ahead*, including in the series broadcasts relating to wartime and postwar developments, with special emphasis on

medical progress of the present day, and what it fore-shadows for the nation's health in the immediate future.

Topics will be announced weekly in *THE JOURNAL* and monthly in *Hygeia*. Fast moving events may, however, cause last minute substitution of topics. Local newspapers should be consulted for announcements of time and stations. The program will be broadcast each Saturday at 4 p.m. Eastern War Time (3 p.m. Central, 2 p.m. Mountain and 1 p.m. Pacific War Time). When conflicts exist with local programs, rebroadcast may be arranged at hours other than on the network schedule. The following are the topics for January:

January 6, Doctors at War.

January 13, Pneumonia.

January 20, Sulfa Drugs (Dr. Austin Smith).

January 27, Penicillin (Dr. Austin Smith).

The broadcast will be under the supervision of the Bureau of Health Education, whose director, Dr. W. W. Bauer, will summarize each program except when other speakers are announced.

**American Society for the Study of Sterility.**—Recently in Chicago the "American Society for the Study of Sterility" was organized. The new organization has for its objectives: 1. The encouragement of scientific investigation of fertility and infertility; 2. The improvement of the diagnosis and treatment of infertility; 3. The correlation and dissemination of the information obtained from these studies.

Among officers who were elected were John O. Haman, M.D., of San Francisco as Secretary, and Lewis Michelson, M.D., of San Francisco as a member of the Board of Directors.

**Lederle Program Stations in Pacific Area.**—"The Doctors Talk It Over" is broadcast coast-to-coast every Friday, and may be heard in your vicinity over the stations and at the local broadcast times listed below:

#### CALIFORNIA

	KERN	1410 K.C.	10:30-10:45 P.M.
Bakersfield	KERN	1410 K.C.	" " " "
Fresno-Visalia	KTKC	940 "	" " " "
Los Angeles	KECA	790 "	" " " "
Riverside	KPRO	1440 "	" " " "
Sacramento	KFBK	1530 "	" " " "
San Francisco	KGO	810 "	" " " "
Santa Barbara	KTMS	1250 "	" " " "
Stockton	KWG	1230 "	" " " "
Watsonville	KHUB	1340 "	" " " "

For the month of January, Nineteen Hundred and Forty-Five, in the Lederle radio program "The Doctors Talk It Over," the following guest speakers were on the program:

January 5, Karl Meyer, M.D., The Hooper Foundation for Medical Research at the University of California. Subject: "Psittacosis or Parrot Fever."

January 12, Wesley W. Spink, M.D., University of Minnesota Medical School. Subject: "Penicillin."

January 19, Paul Dudley White, M.D., Past-President of the American Heart Association. Subject: "Diseases of the Heart."

January 26, Thomas Francis, Jr., M.D., Professor of Epidemiology, School of Public Health, University of Michigan. Subject: "Outlook for the Control of Influenza."

These timely programs will be broadcast coast-to-coast over the Blue Network each Friday evening.

In working days lost per case, tuberculosis heads the list of unnecessary disabilities. This national loss is not due alone to doctors, nor the public health service, nor the ignorance and the carelessness of the people themselves. The blame belongs to all three.—Kendall Emerson, M.D.

## MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.  
San Francisco

### Regulation of Medical Staff by Private Hospital: Admission of Emergency Cases

In the December, 1944, issue of CALIFORNIA AND WESTERN MEDICINE, the general principles governing the regulation of its medical staff by a private hospital were discussed. It was there set out that the rule in the absence of extenuating circumstances is that a private hospital has the right to exclude physicians from membership on its staff and from the use of the hospital facilities, and that such exclusion rests within the sound discretion of the managing authorities of the hospital.

Notwithstanding this right of a hospital to exclude physicians from the use of its facilities and therefore prevent their bringing patients into the hospital, there is the rule of law that a hospital is required to admit certain emergency cases regardless of who may be the attending physician. It is important then to define what is meant by the word "emergency." To determine what is meant by the term "emergency" it is necessary to examine cases which have been decided in analogous situations, where it has been necessary for the court to define that term. The Medical Practice Act (in California, Business and Professions Code, Sections 2,000 to 2,496) in force in most jurisdictions requires an individual to be licensed before he can practice medicine. This rule is subject, however, to the exception that any person may render medical services "in cases of emergency." The cases decided under this Act are helpful in determining the meaning attributed by the courts to an "emergency case."

In *People v. Cosper*, 76 Cal. App. 597, the Court held that there was no emergency which excused the defendant in a prosecution for practicing without a license where the evidence showed that in a maternity case the defendant had treated the patient for a number of days and several hours had elapsed before birth during which time there was ample opportunity to procure the services of a licensed physician.

In *William v. State*, (Neb., 1929) 224 N.W. 286, it was held that an emergency did exist when the exigency of an obstetrical case required some kind of action before the services of a physician could be readily procured. In that case an unlicensed assistant to the physician in charge had rendered medical services when the doctor was not available. The child was born twenty to twenty-five minutes after the defendant had arrived.

With respect to maternity cases, these two decisions indicate that a private hospital would be required to admit a patient as an emergency case where birth is imminent, but where there is ample time to obtain other hospital facilities, the patient could be refused admittance if attended by a physician not privileged to use the facilities of the hospital.

It is a general rule of law that if a physician operates or renders medical or surgical treatment to an individual without his consent, the physician is guilty of an assault and must respond to any damages suffered by the person treated. This rule is subject to the exception that medical and surgical care may be given without a person's consent in cases of emergency where immediate action is necessary to preserve the life or health of the patient. In determining the liability of a physician, the defendant in a court action for injuries suffered as a result of an

operation without consent, the courts have held that a physician or surgeon is justified in applying such treatment as is reasonably necessary for the preservation of life or limb. Undoubtedly the same general rule would be applied in determining whether a private hospital was required to admit a particular patient as an emergency case even though the attending physician was not a member of the medical staff of the hospital. If the patient's condition was such that immediate hospitalization was necessary to save his life or to preserve his health, a private hospital would refuse admittance at its peril, and might be subjected to liability for any loss occasioned by the failure of the patient to receive immediate hospitalization.

The following are examples of cases interpreting the word "emergency" in applying the rule that operations without consent are justified in cases of emergency:

1. Where a fifteen-year-old boy had his foot crushed by a train and an immediate amputation was necessary to save his life the case was held one of emergency.

*Luka v. Lowrie*, 136 N.W. 1106

2. Where a boy of eighteen years had fallen from a train and suffered a severe gash in the head and a mangled arm, amputation of the arm without consent of the parents was justified as an emergency case, such action being necessary to save his life.

*Jackovich v. Yocum*, 237 N.W. 444

3. Operations to remove tonsils have been uniformly held not to constitute emergency cases which justify the physician in proceeding without the consent of the patient or his parents, if a child.

*Coski v. Ganes*, 271 Mich. 1;

*Moss v. Risworth*, 222 S.W. 225

4. The removal of membranous tissue from the thigh of the patient in order to afford sheathing for the tendons of a finger being operated upon was not justified on the ground of emergency.

*Franklyn v. Peabody*, 249 Mich. 363;

228 N.W. 681

5. No emergency exists which justifies operating without the patient's consent upon one ear where the patient has only consented to an operation upon his other ear when there was no immediate danger requiring such action.

*Mohr v. Williams*, 95 Minn. 261;

104 N.W. 12

Additional definitions of the word "emergency" are found in cases where a private physician or a hospital seeks to recover from the county authorities for medical services rendered to indigent persons resident in the county. It is generally stated to be the rule that a physician or a hospital may recover from the county authorities who are bound to provide such services to the poor even though the services were rendered without authorization from the county if they were rendered in "emergency cases." In this connection, it was said in *Cache Valley General Hospital v. Cache County*, 67 Pac. (2d) 639, that an emergency exists "not only where it is apparent that a patient will die unless cared for, but where the circumstances are such that it reasonably appears that there is urgent need of attention to save life." The following are some of the cases defining the term "emergency" in this regard:

1. Where an infection resulting from the amputation of a toe required the further immediate amputation of a leg to save the patient's life, the case was held to be an emergency. *Cache Valley General Hospital v. Cache County*, supra.

2. Acute appendicitis is uniformly held to constitute an emergency.

*Lineback v. Board of Com'rs. of Potowatome*  
(Kan. 1924) 226 Pac. 993;

*Dykes v. Board of Com'rs.*, 121 Pac. 1112

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

3. A broken collar bone has been held to constitute an emergency justifying immediate treatment without authorization from the county authorities.

*Dykes v. Board of Com'rs.*, supra.

4. Severe burns resulting from an oil explosion and fire were held to create an emergency case requiring immediate treatment.

*County of Madison v. Haskell*, 63 III, App.

Although the above cases are helpful in demonstrating what courts have previously held to constitute emergency cases in various situations, it is impossible to prepare an exhaustive list covering all the cases with which a private hospital might be presented. Whether a given case is in fact an emergency requiring immediate hospitalization is at best a question of fact upon which physicians may differ. In order to avoid the possibility of litigation resulting from the death or other disability of a patient denied admission to the hospital, a private hospital should only refuse admittance to those cases which are clearly and obviously not emergency cases. If there is any possibility that the deprivation of immediate hospitalization will cause the patient to die or suffer aggravation of his injury or illness, he should be admitted to the hospital regardless of who may be the attending physician.

## LETTERS †

### Concerning State Medicine in New Zealand:

January 15, 1945.

Dr. George H. Kress,  
Editor, CALIFORNIA AND WESTERN MEDICINE,  
San Francisco, California.

Dear George:

The enclosed clipping I just received from some medical friends of mine in New Zealand where they have had State medicine for about five years and they are all very unhappy about it except the politicians and the labor unions and even the latter are disappointed. The medical profession there feel it is all a terrible mistake!

It is too bad that this legislation is being forced upon the medical profession in California while so many of us are in the military service and unable to protect ourselves.

With kindest regards,

(Signed by a C.M.A. Member in Medical Corps.)

### Doctors Paid by State in New Zealand

#### *Government's Intentions Outlined*

The intention of the Government to encourage medical practitioners to work in coöperative groups under a medical service clinic system was mentioned by the Prime Minister, Mr. Fraser, and the Minister of Health, Mr. Nordmeyer, when replying to the discussion on the Social Security Fund estimates in the House of Representatives on Thursday. Mr. Nordmeyer said there was an increasing tendency, particularly among the younger members of the profession, to regard a State salaried medical service favourably.

The methods of paying the doctors were reviewed by Mr. M. H. Oram (Opposition—Manawatu), who urged that the system of requiring the patients to claim the refund of fees from the State should be instituted. He said there had been untold abuses under the system of the fee for service whereby the doctors claimed on the State.

#### *Attitude of Doctors*

The Prime Minister said he failed to see any difference in the opportunities for abuse between patients and doctors claiming on the fund. Owing to a changed attitude among the doctors many more of them were not now charging the patients, but claiming directly on the fund. He believed that the modern system of having clinics

established with specialists working with practitioners would appeal to the profession.

Personally he thought the clinic system would be more efficient and in keeping with modern training. The doctors could be engaged either as employees of the State or be encouraged to establish coöperative clinics. He felt that more importance should be attached to the preventive side of medical treatment and that people should be encouraged to make constant and early consultations so as to prevent the development of diseases.

Referring to the medical services with the forces, Mr. Fraser said the British command had spoken most highly of the personnel and said there were no better hospitals at the front than ours. Mr. Fraser said he believed that many of these doctors, accustomed to getting a salary and not thinking of medical attendance in terms of income, had got a different outlook and would welcome a scheme where they would not be required to compete for a practice and could give their full services to the community.

The Minister of Health said that probably half of the amount paid for medical services was paid to doctors who accepted the 7s 6d for their consultations. He could not favour the suggestion of reverting to the system of making the patients claim, as it would penalize those now getting free service irrespective of which system was used to pay the doctors. The standard of service depended on the nature and character of the doctors themselves.

Under the present taxation incidence, continued Mr. Nordmeyer, if a doctor received income more than £3700 a year, then for every additional £1000 he earned he received only £100. In other words, for each extra consultation over and above that £3700 he received only ninepence. Those doctors who were drawing high incomes could not possibly give their patients the service they should, but that was largely due to the circumstances that many of our medical men were serving with the forces.

Many of the civilian doctors were greatly overworked, said the Minister, in citing instances. He also believed that many of the younger members of the profession were prepared to consider a salary service scheme through which they could get postgraduate studies, annual holidays and a superannuation scheme.

"We are working out a salary scheme today for those who are willing to come into it," said the Minister.

#### *Refugee Practitioners*

Mr. P. Carr (Government—Auckland West) praised the work of a number of refugee doctors, who, he said, had stepped into the breach when New Zealand doctors were unable to attend patients. He hoped the Opposition would not start out on a heresay hunt against them with the object of driving them out of the country.

The Prime Minister said that if some doctors were receiving £10,000 a year it would be a good thing both for the public and the doctors if the position were looked into.

Mr. Nordmeyer said there was no foundation for the statement that a refugee doctor was earning £5000 a quarter, nor were any refugee doctors earning more than £10,000 a year.

The Leader of the Opposition, Mr. Holland: But some doctors are getting more than £10,000.

The Minister said that it would be improper for him to give the incomes of a small group whereby it might be possible to identify them.—*The Weekly News*, Auckland, New Zealand, October 11, 1944.

### Concerning Medical Journals and Books sent by C.M.A. Postgraduate Committee Hospital Stations of Military Camps in California\*:

(COPY)

STATION HOSPITAL

CAMP CALIAN

San Diego 14, California

November 7, 1944.

Dear Dr. Kress:

Thank you for your letter of October 31, 1944, regarding medical literature. Three packages mailed by you arrived and we wish to thank you for the magazines,

\*Recently, the C.M.A. Postgraduate Committee sent, prepaid, to Hospital Stations of military camps located in California, a total of 118 packets of medical journals and books, having total weight of 2,838 pounds. All Hospital Stations of military camps in California have also been placed on the complimentary mailing list of CALIFORNIA AND WESTERN MEDICINE.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

the two copies of "Social Security" and the Year Book on Radiology. Some of these magazines we already have, yet we will be able to use whatever you send.

I wish to express the appreciation of every medical officer here, as well as that of myself, for this splendid contribution. It is nice to feel that the California Medical Association is keeping the welfare of its members in mind who may be stationed within or without the United States. It is promoting the finest spirit of coöperation and will aid materially in helping the work which we do at this hospital.

I wish to thank you for your offer of the loan of library material and I can assure you that we will be happy to avail ourselves of it.

Gratefully and fraternally yours,

(Signed) MERLE S. HARMON,  
Lt. Col., MC,  
Post Surgeon.

(COPY)

ARMY SERVICE FORCES  
NINTH SERVICE COMMAND  
Headquarters Mitchell Convalescent Hospital  
Camp Lockett, California

C.M.A. Postgraduate Committee,  
San Francisco, California.

Gentlemen:

We wish to express our appreciation for your offer of sending medical books and journals for the use of this station.

These books, when received, will be distributed to the members of our staff, and I feel certain that they will no doubt be interested in them.

We also wish to thank you for your having placed this station on the complimentary mailing list for your official journal, CALIFORNIA AND WESTERN MEDICINE.

The staff will also be advised of your offer for loans of material from the medical libraries in California, which you listed in your letter of October 31, 1944.

For the Commanding Officer:

DONALD GREELY,  
Major, Infantry,  
Adjutant.

#### Concerning Proposal to Lower Medical Licensure Laws in California\*:

(COPY)

P. M. SAVAGE, M.D., F.A.C.S.  
San Bernardino, California

Dear Dr. Kress:

I wish to add my protest against the proposed plan of allowing all ex-army doctors to practice medicine in California upon a reciprocity basis.

We have sent some 40 doctors from our city alone—two of them my own sons—into the service. Myself and many of the other older men are hanging on and continuing the practice of medicine for two reasons only. One is that we feel it our patriotic duty and the other is to have a going practice to hand over to them when they return. If we over-supply California with doctors from other states we will be absolutely betraying a trust to our own men.

Thank you for your alertness in discovering and stopping this unjust procedure.

With kindest personal regards, I am,

Sincerely yours,

(Signed) PHILIP M. SAVAGE, M.D.

\* For discussion of this problem, see CALIFORNIA AND WESTERN MEDICINE, for October, on pages 179 and 211.

#### Concerning "C. and W. M." in Military Camps:

(COPY)

Dear Doctor:

Have been at this station 6 months doing ENT chiefly, as well as some of the minor eye work. We are more than busy and are definitely short-handed as far as doctors are concerned.

CALIFORNIA AND WESTERN MEDICINE that I receive is very much enjoyed by me, and by many of the men from the other States who read it, and praise its quality.

Kindest personal regards,

(Signed) RUSSELL FLETCHER.

#### Concerning Costs of Bubonic Plague Control\*:

STATE OF CALIFORNIA

DEPARTMENT OF PUBLIC HEALTH

Dear Doctor Kress:

In answer to your letter of September 18, attached is a statement of expenditure of funds for plague control for the present biennium and the tentative budget for the coming biennium.

It is quite likely that a large amount of the funds requested for the coming biennium will be diverted to mosquito abatement as related to malaria control. I should say, roughly, one-half of the funds will be used in this way, should they be made available.

Very sincerely yours,

WILTON L. HALVERSON, M.D.,  
Director of Public Health.

#### Concerning Increased Costs of Malpractice Insurance:

(COPY)

San Francisco 4, November 18, 1944

Dear \_\_\_\_\_:

Your letter of November 10, 1944, addressed to Dr. George H. Kress, Secretary of the Medical Society of the State of California has been referred to us. My only suggestion with respect to the increased costs of malpractice insurance offered by Lloyds of London is that you might investigate the rates charged by other companies issuing malpractice policies. In addition to Lloyds of London which uses the standard form of malpractice policy approved by us, we have also examined and found satisfactory the policies issued by the Aetna Casualty & Surety Company and by the Medical Protective Society of Fort Wayne, Indiana. Policies issued by any one of these three companies would be satisfactory.

With respect to Dr. \_\_\_\_\_ who is in the military service, it has been our advice and recommendation that doctors in military service continue to carry malpractice insurance because of the possibility of malpractice action by an injured patient. The fact that a doctor may be in the military service does not absolve him from claims based on negligence which could be made by a soldier, sailor or other member of the military service treated by the doctor. Accordingly, we believe that Dr. \_\_\_\_\_ should have malpractice insurance.

In your letter you ask whether you should continue to carry insurance on Dr. \_\_\_\_\_. We assume that you do not mean insurance covering malpractice actions against the Clinic arising out of the acts of Dr. \_\_\_\_\_ while in the military service. We do not believe that insurance of this type would be necessary.

If you have any further questions, please feel free to call on us.

Very truly yours,

(Signed) HARTLEY F. PEART.

\* For article on incidence of bubonic plague, see CALIFORNIA AND WESTERN MEDICINE, for October, 1944, on page 218.

## TWENTY-FIVE YEARS AGO†

### EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVIII, No. 1, January, 1920

#### EXCERPTS FROM EDITORIAL NOTES

**1920 Resolutions.**—There is a remote region where there are no coal strikes and where the atmosphere is most ardent that is described by sacred writers and theological commentators as a place paved with good resolutions. It is not the making, however, but the breaking of good resolutions that prepare them for such paving purposes. . . .

Resolute men and women who never let the native hue of resolution be "sicklied o'er with the pale cast of thought" have blazed the way in every useful field of human endeavor, particularly in the field of medicine.

During 1920 several acid tests will be applied that will determine the real interest that every ethical member of our profession in this State takes in the progress of scientific medicine. Measures will confront us on the 1920 ballot that are definitely designed to undermine the very foundations of scientific research and create chaos in the administration of our Medical Practice laws. . . .

During the year that has passed since Armistice Day there has been time to accumulate and appraise a large part of the valuable health lessons that have come out of the war. . . .

Let no one vainly try to do during 1920 what can only be accomplished by concerted effort. The biggest things in life cannot be accomplished by one individual playing a solitary game. It has been well said that the person who thinks he can get along without others is foolish, and if he thinks others cannot get along without him he is a fool.

As a permanent 1920 resolution, let us cultivate the coöperative spirit and all highly resolve, that by applying the helpful agencies known to modern medicine, we will make our part of the world a better place to live in, and that unselfishly and unflinchingly we will fulfill our professional and civic duties.

In this way we will not only initiate a new calendar but a new era of development.

#### EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

*From an Article on "Question of Improving Business Methods and Increase of Fees," by P. A. Jordan, M.D., San Jose, California.*—Physicians as a class are untrained in business, and the physician's professional work is usually carried on in an unbusiness-like manner. His business methods may be improved by following the succeeding suggestions.

The arrangement of the physician's office is often not of the best. . . .

Having secured a good plant with which to carry on his business, it remains for the physician to sell his services to his patrons as truly as does the clerk in the department store. . . .

I think one of the most important points in the business life of the physician, and the one which is most often neglected, is a heart to heart talk with the patient at the time of his first visit. . . .

(Continued in Back Advertising Section, on Page 48)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco, 8.

## BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M. D.

Secretary-Treasurer

### Board Proceedings

Only 37 applicants presented themselves for written examination at the October meeting of the Board. This examination was held in the Business and Professions Building in Sacramento. The results of said written examination will be released at an early date.

At the recent oral examination held in San Francisco 75 examinees presented themselves for oral examination. These included physicians who had been licensed in other states more than ten years ago, as well as members of the armed forces, who applied on an examination not considered equal to the California examination given on the same date. This was one of the largest groups of oral examinees we have had. There was a higher percentage of failures in this examination than has been previously recorded.

The next written examination will be held in Los Angeles February 27-March 2, 1945. The next oral examination will be held at Elks Club, in Los Angeles, January 21, 1945.

The Board of Medical Examiners was ordered by the Superior Court of San Francisco on October 17, 1944, to restore the certificate of Lilly L. Koerber, previously revoked. The Board, in compliance with the Court Order did restore this certificate; however, an appeal has been filed which will be heard in the near future.

### News

"Regular law and motion calendar of the fourth district court of appeal will be held next Tuesday at the court's San Bernardino headquarters, 263 Third Street. Fifteen cases are set for hearing, including the appeal of Dr. Clyde A. Pierson, appealing from a conviction of abortion. It is likely, however, that the Pierson case will be continued to the December calendar of the court of possibly to the January calendar in Fresno." (San Bernardino Telegram, November 9, 1944.)

"And now it's the 'green death'—add this term to the colorful demi-world expressions which have come into use among thrill-seekers to describe the modern drugs which they find can produce more of a jag than liquor. According to H. F. Dowdy and L. M. Bales, inspectors for the State Board of Pharmacy, who are engaged in a widespread campaign to curb illegal sale of the drugs, not only juveniles but many adults have taken up their use." . . . (Los Angeles Herald and Express, November 27, 1944.)

"On his plea of guilty in police court this morning to a charge of loitering around a school ground, Dr. Clarence H. Koennecke, 41, of 813 North Granada Avenue, Alhambra, had his case continued for sentence until next Wednesday morning. The suspect was released on \$500 bail and Judge Kenneth C. Newell requested further investigation be conducted. Dr. Koennecke was arrested on

(Continued in Back Advertising Section, on Page 48)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.